UNIVERSITY OF CALIFORNIA SAN DIEGO

To Serve and To Heal: Native Peoples, Government Physicians, and the Rise of a Federal Indian Health Care System, 1832-1883

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy

in

History

by

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The Dissertation of Kelly Bokosky Silva is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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DEDICATION

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TABLE OF CONTENTS

LIST OF TABLES

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ABSTRACT OF THE DISSERTATION

To Serve and To Heal: Native Peoples, Government Physicians, and the Rise of a Federal Indian Health Care System, 1832-1883

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Professor Rachel Klein, Chair

Beginning in the 1830s, a nascent federal Indian health care system emerged in conjunction with the acquisition of indigenous lands. This system began with provisions for physicians' care and the distribution of smallpox vaccines. It expanded over the course of the 1840s and 1850s to include the employment of physicians across reservation, the deployment of military and civilian physicians to treat Native peoples at the centers of smallpox outbreaks, and federal funds for the construction of reservation hospitals. This expansion of federal power in the West served both federal and Native interests. For some Native peoples, engaging in health care services was an adaptive strategy at a time when the power dynamics between themselves and the federal government had shifted dramatically. Removal and the westward expansion of America's white settler population exposed many Native peoples to the spread of infectious

diseases. While many retained and utilized their traditional healers, the flexibility of indigenous world views and medical practices allowed for the integration of federal health care services into their communities. Physicians, however, were first and foremost agents of the state. Their care helped facilitate removal, appease moral apprehensions over the direction of US-Indian policy, protect white settler communities at the periphery, and held promise to support a healthy labor force.

Federal responsibility and oversight of Native health became part of the bureaucratic administration of Indian Affairs in 1873 with the formation of a Medical and Educational Division. Within this structure physicians helped the federal government to construct Native health as a marker of racial and cultural difference, as the product of behavior rather than the result of governmental policies. Within this new structure, physicians provided the state with justification for its increasingly invasive intervention into Native lives. Examining the expanding role of physicians alongside the bureaucratization of Indian health services connects this project to the broader national narrative of the expansion of federal power and governance in the second half of the nineteenth century, particularly the changes and transformations during the period of Reconstruction. It also reveals how the extension of empire evolved into political contestations not only over land, but also Native bodies.

Introduction

The Indian Health Service (IHS), "the only national health program in American history for civilians,"[1] exists today as a government agency within the Department of Health and Human Services. It provides free federal health services to American Indian and Native Alaskan members of the five hundred and sixty-seven tribes federally recognized within the United States.[2] In communicating its purposes as well as its origins, the IHS presents the relationship between American Indian health and the federal government as a concept that grew organically alongside the "guardian/ward relationship" that emerged following such Supreme Court decisions as *Johnson v. M'Intosh* (1823) and *Cherokee Nation v. Georgia* (1831).[3] These cases expressed the relationship between the two sides as paternalistic and benevolent; one that offered Native peoples protection and "relief of their wants." They also significantly limited Native peoples' rights to their lands, diminished their standing within the nation to "domestic dependent nations," and provided a legal backbone upon which the appropriation of indigenous lands could take place. In any case, the origins of the IHS and the relationship between the federal government and Native health has a more complex history than the official story suggests. The agency emerged in the context of war, conquest, dispossession, and disease.[4] Its history

[1] Cary C. Collins and Charles V. Mutschler, eds., *A Doctor among the Oglala Sioux: The Letters of Robert H. Ruby, 1953-1954* (Lincoln: University of Nebraska Press, 2010): xxix.

[2] Indian health services originally operated within the Bureau of Indian Affairs (BIA). On July 1, 1955 the operation and maintenance of Indian hospitals and health services was transferred to the United States Public Health Service (USPHS) under administration by the Secretary of Health, Education and Welfare.

[3] "About IHS," The Indian Health Service: The Federal Health Program for American Indians and Alaskan Natives, http://www.ihs.gov/aboutihs/.

[4] I examine colonialism not as an event, but as a process that structures later interactions, decisions and events. While Native peoples sought to mediate the expansion of US empire in the early decades of the 19th century, US policymakers and officials centered their efforts on land dispossession. The United States, like Australia, Canada, and New Zealand, followed a model of settler colonialism that involved not only conquest but also control over the dispossessed. See: Patrick Wolfe, "Settler Colonialism and the Elimination of the Native." *Journal of*

demonstrates how the extension of American empire involved political contestations not only over land, but also Native bodies.

Beginning in the 1830s, a nascent federal Indian health care system emerged in conjunction with the acquisition of indigenous lands. The system began with provisions for physicians' care during the removal process and the distribution of smallpox vaccines as part of the 1832 *Indian Vaccination Act*. It expanded over the course of the 1840s and 1850s to include the employment of government physicians across reservation communities, the deployment of military and civilian physicians to treat Native peoples at the centers of smallpox outbreaks, and federal funds (per treaty stipulations) for the construction of reservation hospitals. Federal responsibility and oversight of Native health became part of the bureaucratic administration within the Indian Office in the late nineteenth century with the formation of the Medical and Educational Division in 1873. The activities instituted in the 1870s served as the model for the government's management of Indian health care over the next fifty years. Within this structure physicians helped the federal government to construct Native health as a marker of racial and cultural difference, as the product of behavior rather than the result of governmental policies, and provided the state with justification for the increasingly invasive intervention into Native lives.

Native groups facilitated the rise and expansion of this system because many of them saw a benefit in utilizing the services of government physicians and integrating western medical practices into their communities. Removal not only tore them away from their ancestral homelands and threatened their sovereignty as a people; it also created circumstances that increased their vulnerability to the spread of infectious diseases, including smallpox, cholera, and measles, to name a few. While many Native groups retained and utilized their traditional healers,

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Genocide Research 8, no. 4 (Dec 2006): 387-409; Eve Tuck and K. Wayne Yang. "Decolonization is Not a Metaphor." *Decolonization: Indigeneity, Education and Society* 1, no. 1 (2012): 1-40.

changing circumstances led many to look for alternative sources of healing, including medicines and medical care from government physicians. Engaging in health care services was an adaptive strategy at a time when the power dynamics between Native peoples and the federal government shifted drastically.[5] Most Native groups who received federal health care services had ceded large portions, if not all, of their homelands. They faced removal and relocation to designated territories west of the Mississippi River and later confinement to reservations. Utilizing and sometimes requesting physicians' care came at moments of great vulnerability and was a choice made to serve the interests of their tribal members. Unfortunately, Native collaboration in the development and expansion of federal health care services facilitated the spread and scope of American empire, the consequences of which became more pronounced in the latter decades of the nineteenth century.[6]

While many Native peoples saw physicians as sources of healing, physicians were first and foremost agents of the state and their activities on behalf of the government became more aggressive after the Civil War. Physicians who worked among Native peoples during the decades of westward expansion worked at the behest of the federal government often assisting federal soldiers during military campaigns, accompanying exploratory expeditions to map western lands intended for federal expansion, and aiding in the forced removal of Native peoples

[5] For scholarship that examines Native responses to colonization, see: Ned Blackhawk. *Violence Over the Land: Indians and Empires in the Early American West*. Cambridge: Harvard University Press, 2006.; Lisa Brooks. *The Common Pot: The Recovery of Native Space in the Northeast.* Minneapolis: University of Minnesota Press, 2008.; Elizabeth A. Fenn. *Encounters at the Heart of the World: A History of the Mandan People.* New York: Hill and Wang, 2014.; Howard L. Harrod. *Becoming and Remaining a People: Native American Religions on the Northern Plains*. Tucson: University of Arizona Press, 1995.; James H. Merrell. *The Indians' New World: Catawbas and their Neighbors from European Contact through the Era of Removal*. New York: W. W. Norton & Co., 1989.; Richard White. *The Middle Ground: Indians, Empires, and Republics in the Great Lakes Region, 1650-1815.* Cambridge: Cambridge University Press, 1991.

[6] Many scholars have examined the unintended consequences of Native survival strategies reinforcing the colonial power structure. See: Steven W. Hackel. *Children of Coyote, Missionaries of St. Frances: Indian Speaking Relations in Colonial California, 1769-1850*. Chapel Hill: University of North Carolina Press, 2005.

from their homes.[7] These physicians were initially supplied through the War Department. Army surgeons were contracted to treat Native patients in addition to their primary post duties serving the needs of the military. After 1849 when Congress transferred the Office of Indian Affairs (OIA) from the War Department to the Department of the Interior, officials increasingly turned to civilian physicians to serve the agenda of the OIA.[8] In the decades after the Civil War, these civilian physicians served an increasingly aggressive and expansive state and became important intermediaries in monitoring and controlling reservation populations.

In the first half of the nineteenth century, it was not difficult for Native peoples to navigate between their traditional medicine ways and western medicine. Government physicians played limited and often temporary roles among tribes and the flexibility of indigenous healing traditions allowed for the incorporation of the healing power of western medicine without requiring an abandonment of their traditional medicine ways. In many instances, observations by physicians who worked among Native peoples in these early decades reveal medicine men who were adept at meeting most of the needs of their patients. Some government physicians incorporated Native therapeutic treatments into their own medical practices. Others tried to suppress the power of the medicine men, but their efforts were often futile and left them frustrated.

[7] Mary C. Gillet, *The Army Medical Department, 1818-1865* (Washington D.C.: United States Army, 1986), 53-72; J. Diane Pearson, "Lewis Cass and the Politics of Disease: The Indian Vaccination Act, of 1832," *Wicazo Sa Review* 18, no. 2 (Fall 2003), 17.

[8] When it came to medical care for Native peoples confined to reservations, Mary Gillet argues that an agreement was made with the Indian Office and the Army "that the Army would play no role in their management unless the bureau requested aid." This included medical care which Gillet acknowledged "was rarely among the Army physician's responsibilities" after this transfer. However, there were some occasions where Army surgeons were assigned to care for Native patients living on reservations. Mary C. Gillet, *The Army Medical Department, 1865-1917* (Washington, D.C.: United States Army, 1995), 81.

After the Civil War, the ability to navigate between traditional medicine ways and western medicine became much more difficult for Native peoples. A more aggressive state rationalized deeper intrusion into Native lives with "detribalization" and the destruction of Native cultural practices and lifeways as the ultimate goals.[9] Physicians became much more important figures in the administration of the colonial state as their presence across reservations increased and their role within the state expanded. In 1873, Indian Commissioner Edward P. Smith extended administrative oversight over this vast medical network existing across reservations and created a Medical and Educational Division within the Office of Indian Affairs.[10] Physicians' work was not limited to treating the sick, but included documenting rates of sickness, morbidity and mortality on the reservations. The narratives of ill health that emerged from these physician reports reflect the human costs of colonialist policies that disrupted Native communities, crippled "existing Indian subsistence systems," and provided justification for the continued and increasingly invasive intervention into Native lives by the federal government.[11] For Native peoples, the continued reliance upon traditional medicine become a means of contesting late nineteenth century US colonial policies.

This dissertation navigates between charting the rise and expansion of federal health care services to many different Native groups, including the Choctaw, Ojibwe, and Nisqually, while simultaneously charting how one group, the Ho-Chunk, interacted with this system over time. The Ho-Chunk, or Winnebago, were one of the earliest tribes to engage with federal efforts to

[9] Steven Hahn, *A Nation Without Borders: The United States and Its World in An Age of Civil Wars, 1830-1910* (New York: Viking, 2016), 377-382. Richard White, *"It's Your Misfortune and None of My Own": A New History of the American West (*Norman: University of Oklahoma Press, 1991), 108-117.

[10] R. A. Wilbur. "Suggestions in Regard to the Management of These Reservations." United States. Office of Indian Affairs. *Annual Report of the Commissioner of Indian Affairs, for the year 1873* (Washington, D.C.: G.P.O., 1873), 64. http://digital.library.wisc.edu/1711.dl/History.AnnRep73. (hereafter cited as *ARCIA*)

[11] White, *It's Your Misfortune,*113.

provide medical care, and their continued utilization of these resources make it possible to explore how their relationship to these physicians changed over time, particularly in the decades following the Civil War.[12] The Ho-Chunk ("People of the Big Voice") trace their origin to *Mogasuuc*, Green Bay in their native language. Prior to the period of white settlement, they occupied more than ten million acres of land in what is now Wisconsin and northern Illinois. This would later place them at the vortex of tension between the federal government and Indians of the Great Lakes.[13] These tensions carried over from the Seven Years War and intensified during the American Revolution and the War of 1812.[14] Their participation in the Winnebago Uprising of 1827 and Black Hawk's War of 1832 resulted from their resistance to increased American efforts to acquire the mineral rich lands of Wisconsin and Illinois.[15] It was in the midst of these conflicts that the Ho-Chunk people first engaged with federal health care efforts in the region and secured continued access to these services. The cost of securing these provisions, however, was great. It involved the cession of portion of their homelands.

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[12] In 1994, the tribal government in Wisconsin officially changed their name to Ho-Chunk, the name for themselves meaning *People of the Big Voice*. Winnebago was a term given to the tribe by their Algonquian neighbors meaning *People of the Muddy Waters* and is the term used to refer to the tribe in the historical record. Today, the tribal nation is split between the Ho-Chunk Nation of Wisconsin and the Winnebago Tribe of Nebraska. For the purposes of this paper, I have chosen to use the term Ho-Chunk. See: Tom Jones, *People of the Big Voice: Photographs of Ho-Chunk Families by Charles Van Schaick, 1879-1942* Madison: Wisconsin Historical Society Press, 2014.

[13] Amy Lonetree, "Visualizing Native Survivance: Encounters with my Ho-Chunk Ancestors in the Family Photographs of Charles Van Schaick," *People of the Big Voice: Photographs of Ho-Chunk Families by Charles Van Schaick, 1879-1942* (Madison: Wisconsin Historical Society Press, 2014), 15.

[14] White, *Middle Ground*, 408-412.

[15] Alan Taylor examines the complex alliances made between Native peoples and both the British and US as intertwined with divisions amongst Indian tribes. These actions were facilitated by British policies that encouraged the idea of an Indian borderland between the two nations and supported the formation of an Indian confederation in the Great Lakes region. In contrast, American policy envisioned a "white man's republic premised on subduing Indians as savages." It wasn't until American losses that policy was changed to seek Indian allies. Tensions increased in the region following the Revolutionary War as the United States looked to the lands of the Great Lakes region that had been acquired in 1783 in the peace treaty between Britain and the United States as an economic opportunity to solve the country's debt crisis accumulated during the war. Alan Taylor, *The Civil War of 1812: American Citizens, British Subjects, Irish Rebels, & Indian Allies* (New York: Alfred A. Knopf, 2010), 15-43, 159, 203-233. See also: John W. Hall. *Uncommon Defense: Indian Allies in the Black Hawk War*. Cambridge: Harvard University Press, 2009; Patrick J. Jung. *The Black Hawk War of 1832*. Norman: University of Oklahoma Press, 2007.

Subsequent treaties between the Ho-Chunk and the United States in 1837, 1846, 1855, 1859 and 1865 tell a story of repeated land cessions and forced relocations and reveal the human costs that accompanied federal removal policy. During this difficult period of their history as a people, the government expelled them from their home in Green Bay to reservations in Iowa, Minnesota, and South Dakota. It was their experiences in South Dakota that led to a permanent fracturing of the tribe. Many made their way to Nebraska where they negotiated a final treaty with the federal government to secure a reservation on the lands of the Omaha Nation. Others, who repeatedly returned to their ancestral homelands in Wisconsin throughout their many removals and relocations, returned once again during the Civil War years and gained the ability to remain there permanently in 1881. This is a testament to their survival and resilience as a people. Today, they are split into two federally recognized tribes, the Ho-Chunk Nation of Wisconsin and the Winnebago Tribe of Nebraska. Their story ultimately reveals the complicated history behind what today exists as the Indian Health Service as well as the limits of federal efforts to replace traditional Native healing with western medicine.

Without denying the critical significance of Reconstruction in the development of the Federal bureaucracy, nor the South as a space where much of this took place, I join other recent scholars who have argued that the West was a critical site for the expansion of federal power even before the Civil War. Scholar Steven Rockwell argues that a critical examination of the Indian Office in the first half of the nineteenth century "reveals a vibrant, complicated federal bureaucracy, planning and performing complex and difficult tasks in politically charged environments, full of debate over means and ends and carried out with vast grants of discretionary authority to federal field agents deployed across the continent, and doing so long

before the Civil War and the New Deal." [16] Similarly, Richard White argued that in the American West a "powerful state began to develop" even if "only in fledgling forms" during this period. My work moves this argument forward by showing how federal power expanded at the periphery. Unlike others who focus on centers of power, I show how power was negotiated on the ground between Native groups and agents of the state who had their own distinctive histories and perspectives.

However, unlike many historians who root this expansion of power at the center of government, the expansion of this nascent Indian health care system advanced largely through the work of federal agents working at the periphery. [17] Relying upon Margot Canady's definition of the state as "what officials do," I argue that local Indian agents, regional superintendents, and federal commissioners, tasked with negotiating treaties, expanded federal health care services to Native peoples and helped create a nascent health care system in the decades leading up to the Civil War. [18] It was through their activities that physicians became an increasingly common presence across reservation communities and one of its defining features.

The expansion of federal power in the trans-Mississippi West during the period of antebellum Indian Removal has largely been overlooked by historians of Reconstruction. Most scholars look at the Civil War and the creation of the Freedman's Bureau at the conclusion of the war as "a watershed in the history of federal power."[19] For example, Jim Downs, who explores

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[16] Stephen J. Rockwell, *Indian Affairs and the Administrative State in the Nineteenth Century* (Cambridge: Cambridge University Press, 2010), 3; White, *It's Your Misfortune*, 58.

[17] William J. Novak, "The Myth of the 'Weak' American State," *The American Historical Review* 113, no. 3 (June 2008): 766.

[18] Canady argues, "We can see the state through its practices; the state is 'what officials do.' And by officials, I mean not only top decision-makers but bureaucrats at all levels." Margot Canady, *The Straight State: Sexuality and Citizenship in Twentieth-Century America* (Princeton: Princeton University Press, 2011), 5.

[19] Jim Downs, *Sick from Freedom: African-American Illness and Suffering during the Civil War and Reconstruction* (London: Oxford University Press, 2015), 12. See also: Drew Gilpin Faust. *This Republic of Suffering: Death and the American Civil War.* New York: Vintage Books, 2008; Eric Foner. *Reconstruction:*

the activities of the Medical Division of the Freedmen's Bureau in the post-Civil War South and "the complicated legacy of freedom" for black Americans, argues that when the Freedman's Bureau shifted responsibility for freedpeople's health to the states, it transplanted its infrastructure West to federal reservations and provided the backbone for a national strategy regarding American Indian health. Downs proposes interesting and important connections looking at the formation of the Education and Medical Division in relation to the work of the Medical Division of the Freedmen's Bureau. But this dissertation suggests that it would be fruitful to look at these relationships in reverse by examining the ways that antebellum policies towards American Indians might have helped set the stage for the work of the Freedmen's Bureau in the 1860s.

This project draws upon and contributes to the work of scholars who have turned their attention to the implementation of federal policy by government officials at the local level to reveal the ways that state power functioned at the edges. In "The Myth of the 'Weak' American State," William Novak challenges the dominant narrative of America's past as "a usually benign tale of legal-political self-abnegation, emphasizing constitutional restraints such as federalism, checks and balances, the separation of powers, limited government, the rule of law, and laissez-faire."[20] He argues this myth has reinforced America's perception of itself and its past as exceptional and has masked the power of the American state from its early republican days to the present. Novak proposes that a pragmatic and realist approach might better serve in measuring the power of the American state by asking "how" questions: "how officials, acted, how policy was made, how government functioned." By tackling the work of those implementing policy at

America's Unfinished Revolution, 1863-1877. New York: Harper Collins Publishers, Inc., 1988; Hahn. *A Nation Without Borders.*

[20] Novak, "The Myth of the 'Weak' American State," 752.

the local level - tax collectors, police, and grand juries - it becomes clearer how the myth of an American state can best be unmade and the realities of state power can be assessed. In order to achieve this, he challenges historians to look away from the center of government. He argues that "to try to gauge the power of the American state or the reach of American public policy by looking simply at the national center or the federal bureaucracy is to miss where much of the action is – at the local and state levels – on the periphery."[21] This project accepts Novak's challenge. By examining the activities of physicians who became increasingly common within Native communities, and later across reservations, it is possible to see the expansion of federal power throughout the 1830s, 1840s, and 1850s. It was the work of individuals operating at the periphery who expanded these federal health care services to Native peoples to serve state and white settler interests at critical moments in time.

While I argue that local agents at the periphery worked to expand this nascent federal Indian health care system beginning in the 1830s, I also recognize Reconstruction as a moment of great change in the administration, management, and function of the Native health care system. Examining the expanding role of physicians alongside the bureaucratization of Indian health services after the Civil War connects this project to the broader national narrative of the expansion of federal power and governance in the second half of the nineteenth century, particularly the changes and transformations during the period of Reconstruction. Scholars have argued that the period from the end of the Civil War to the later 1870s saw the empowerment of the nation-state and changes in the very meaning of national citizenship. [22] The formation of a Medical and Education Division in 1873 reveals how Republican led state-building activities

[21] Ibid, 765-766.

[22] See: Faust. *This Republic of Suffering* (2008); Foner, *Reconstruction* (1988); Hahn, *A Nation Without Borders*, (2016).

during the period of Reconstruction extended into the Office of Indian Affairs. Further, it provides scholars another avenue to examine how Reconstruction impacted US-Indian relations and the administration of Indian Affairs.

This project engages with recent scholarship that broadens the geographical scope of Reconstruction and incorporates American Indians more fully into the historical narrative. *The Civil War and Reconstruction in Indian Territory*, edited by Bradley R. Clampitt, is comprised of a collection of essays that examine the complicated impact of this period in "a region populated predominantly by people who were neither Northern nor Southern and indeed were not U.S. citizens."[23] In particular, Christopher B. Bean's essay, "Who Defines a Nation?: Reconstruction in Indian Territory" examines the ways the federal "government used Reconstruction to reshape the relationship with indigenous peoples," assert federal control into tribal matters, and undermine Native sovereignty. This policy was part of a national process of reimagining with "the ultimate objective of unifying the nation under similar values and institutions."[24] In *American Heathens*, Joshua Paddison examines race, religion, and the making of a white national identity in California and reveals how Reconstruction "was a multiracial and multiregional process of national reimagining."[25] In *Color of the Land*, David Chang examines the complex legacy of Indian Removal, Reconstruction and later federal policies including the Dawes Act on meanings of citizenship, identity, race relations, and land ownership in Oklahoma among white Americans, African Americans, and Creek citizens.[26] This project adds to this scholarship by

[23] Bradley R. Clampitt, "Introduction." *The Civil War and Reconstruction in Indian Territory*, ed. Bradley R. Clampitt (Lincoln: University of Nebraska Press, 2015), 1.

[24] Christopher B. Bean, "Who Defines a Nation?: Reconstruction in Indian Territory," *The Civil War and Reconstruction in Indian Territory*, ed. Bradley R. Clampitt (Lincoln: University of Nebraska Press, 2015), 110-111.

[25] Joshua Paddison, *American Heathens: Religion, Race, and Reconstruction in California (*Berkeley: University of California Press, 2012): 5.

[26] David Chang. *The Color of the Land: Race, Nation, and the Politics of Landownership in Oklahoma, 1832-1929*. Chapel Hill: University of North Carolina Press, 2010.

examining how physicians, under the new bureaucratic arm of the Medical and Educational Division, became important state intermediaries in state efforts to replace cultural and religious values, by targeting the role of traditional healers and "medicine men" within reservation communities, with that of white America.

In examining the cross-cultural interactions between Native groups in the Great Lakes and government physicians in the first half of the nineteenth century, this project challenges two dominant narratives that have been perpetuated about interactions between Native peoples and western medical practitioners. The first portrays Native peoples as recipients of federal health care, accepting some practices that did not challenge their traditional beliefs, but most often rejecting government services for medical care. The second narrative presents the relationship between Native peoples and physicians as one of conflict and opposition.[27] There is truth in this narrative. In the latter decades of the nineteenth century, the relationship between these parties did become more antagonistic as a more aggressive state emerged and more concerted efforts were made to assimilate Native peoples. As historian Robert Trennert argues in his study of the relationship between the Navajo (or Dine) and government physicians, conflicts over healing "became involved with the government's determination to destroy native culture and replace it with the values of white America."[28] This included the targeting of traditional healers and sacred objects such as medicine bundles. Neither one of these narratives, however, acknowledges Native agency and collaboration in the development and expansion of what would become a

[27] Robert A. Trennert, *White Man's Medicine: Government Doctors and the Navajo, 1863-1955* (Albuquerque: University of New Mexico Press, 1998), ix-x, 39-40. See also: Holly T. Kuschell-Haworth, "Jumping through Hoops: Traditional Healers and the Indian Health Care Improvement Act," *DePaul Journal of Health Care Law* 2, no. 4 (Summer 1999), 843-860.

[28] Trennert, *White Man's Medicine,* 1.

federal Indian health care system. Nor do they explore the emergence of these interactions in the pre-Civil War decades.

This project also joins historical scholarship that examines the complexity of ways Native peoples engaged with American empire and the strategies they employed as they confronted an expanding American state to retain their cultural, social, and religious identities and their sovereignty as a people. In *Federal Fathers & Mothers*, Cahill examines the actions of the men and women who translated policy into action on reservations and at Indian schools to reveal the disconnect between government intentions to remodel Indian families based on heteronormative standards and the work of Native peoples to use federal employment as a way to continue to live within their communities, retain their tribal identities and build larger kinship networks across reservations. Cahill reveals "how the everyday lives of the employees interacted with and shaped federal policy" to create something very different than what was originally intended and that would later function as a foundation for political action.[29] Cahill does not downplay the devastating impact of federal policies that sought to break apart families and sever Native ties to their lands and their communities. Yet, she also does not paint Native peoples as passive recipients of "assimilation era" federal policies. What emerges then is a more nuanced and complex portrait of the unintended consequences of the creation of a permanent bureaucracy, the Indian Service, in the late nineteenth and twentieth centuries for those employed within its service and the communities it worked to transform.[30] This project seeks to do something similar. Native engagement and collaboration in the expansion of a nascent federal Indian health care system was an adaptive strategy that came with costs and benefits to those Native groups

[29] Cathleen D. Cahill, *Federal Fathers & Mothers: A Social History of the United States Indian Service, 1869-1933 (*Chapel Hill: University of North Carolina Press, 2011), 11.

[30] Ibid, 104-135.

who sought these services. On the one hand, accessing western medicine meant incorporating physicians, agents of the state, into the intimate lives of their people. On the other hand, many saw it as necessary to combat the increased rates of sickness, suffering and death that followed removal, relocation, and confinement to reservations. The unintended consequences of this collaboration became apparent in the late nineteenth century as physicians and federal health care services became instruments for state intervention.

This project joins scholars of Native studies who have presented a rich body of scholarship centered on themes of adaptation and change as central to Native survival and continuance. In *The Common Pot,* Lisa Brooks has argued that a "focus on questions of authenticity, and the maintenance of binaries that assume that the adoption of Christianity or literacy is concomitant with a complete loss of Native identity, has obscured the complex ways in which Native communities have adopted and adapted foreign ideas and instruments in particular places."[31] While Brooks is concerned with recovering the literary heritage of Native writers in early America not as inauthentic, but rather a powerful tool of resistance to colonialism, her arguments align with my own - that confronted with federal efforts at land acquisition and increasing rates of disease and death, Native peoples reserved and extended access to western medicine as one of many tools for survival during the nineteenth century. More connected to this project is Elizabeth Fenn's *Encounters at the Heart of the World* in which she explores the rich history of the Mandan people and the complex ways they responded to changes brought by Europeans – namely disease, horses and Norwegian rats. While the Mandans succumbed in great numbers to whooping cough, measles and other infectious diseases, it was smallpox that proved to be the most devastating, particularly the epidemic of 1837, that nearly

[31] Brooks, *The Common Pot*, xxxi

wiped them out. Fenn credits "their resilience and flexibility on the one hand and their traditionalism on the other" for the survival and continuance as a people.[32] The traditionalism that Fenn alludes to is the Okipa ceremony, a ceremony central to their distinctive identity as Mandans that itself provided the Mandans with the flexibility to adapt to changing circumstances. At its core, Mandan spiritual life and the Okipa ceremony "was *supposed* to change with the people themselves." It was the ability of the Okipa to evolve, to embrace new elements and abandon others no longer useful, that Fenn argues "allowed the Mandans to preserve their identity in the face of change, both before and after 1492."[33] Fenn's work provides an excellent example of the primacy of ritual and ceremony to understanding Indigenous perspectives and world views and their continuance and survival in the face of colonization. I argue throughout this project that Native collaboration, founded upon the flexibility of their world views and medical systems, was paramount to the expansion of this nascent federal Indian health care system throughout the first half of the nineteenth century.

In writing this dissertation I benefitted from prior studies that focused on the interplay between medicine, public health policy and colonialism. In *Colonial Pathologies*, Warwick Anderson considers the ways colonialism, paternalism, race and public health shaped the application and formation of a distinct form of tropical medicine in the Philippines. The technical discourse of hygiene became a significant arena within which policy makers promoted the civilizing mission of the American government as well as the Americanization of Filipinos. Anderson argues that identification and control of individuals and the regulation of personal conduct became the central tenets of American tropical medicine and that hygiene and sanitation

[32] Fenn, *Encounters at the Heart of the World*, xiv.
[33] Ibid, 100.

became the disciplinary tools.[34] While Anderson sees America's project in the Philippines as connected to later international development projects, he forecloses any connections to be made between America's civilizing project at home and abroad. He argues that federal Indian health care "was hardly more than gestural and decorous, a poor excuse for expropriation of land." I disagree with his assessment of federal Indian health care policy. I believe domestic colonial projects, including the Medical and Educational Division of the Indian Office, were foundational to later imperial projects abroad.

This project has especially benefited from scholarship that examines the interplay of race, medicine, and public health policy towards indigenous peoples in Canada. In "Race, Culture, and the Colonization of Childbirth in Northern Canada," Patricia Jasen examines how Euro-American ideas about aboriginal bodies, particularly women's bodies in labor, perpetuated notions of biological "difference" between Canadians and First Nations people in the nineteenth century. She points out that racist ideas enabled Canadian officials to blame high rates of maternal and infant mortality on traditional childbirth practices rather than colonial policies by the government.[35] In *Colonizing Bodies*, Mary-Ellen Kelm argues that despite a colonial narrative that perpetuated the idea of Native bodies as naturally weak and predisposed to illness, there remained great strengths among First Nations people throughout the twentieth century in regards to their health and well-being.[36] As both scholars demonstrate, Canadian public health policy was largely shaped by racist assumptions about indigenous bodies and functioned to perpetuate myths about biological difference and susceptibility to disease. Government policies

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[34] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006), 58.

[35] Patricia Jasen, "Race, culture, and the colonization of childbirth in northern Canada," *Social History of Medicine* 10, no. 3 (1997): 383-400.

[36] Mary-Ellen Kelm. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950.* Vancouver: University of British Columbia Press, 1998.

in the United States operated in a very similar fashion. Federal officials initiated a vicious cycle that both produced and perpetuated health crisis within Native communities. Narratives of ill health, compiled by reservation physicians, were then used to implement increasingly intrusive policies that sought to disrupt kinship networks, familial ties and community autonomy.

This project examines the rise of a nascent federal Indian health care system through an analysis of military correspondence, published Annual Reports by the Office of Indian Affairs, internal correspondence between officials within the Indian Office, financial statements and records, published Congressional debates, newspaper publications, published journals and diaries, and ratified treaty documents. Many of these sources were written by federal officials and citizens whose writings were often clouded with nineteenth century prejudices towards Native peoples. To bring indigenous voices and perspectives into this narrative, I also rely upon transcripts of treaty council meeting minutes and meetings between federal officials and Native peoples.

This project relies upon anthropological sources to understand Native participation in the creation of this system and their perspectives on issues of health, healing, and sickness in the nineteenth century. Especially useful is the rich body of research produced in the late nineteenth and early twentieth centuries by anthropologists Paul Radin and Walter James Hoffman. Paul Radin is perhaps the greatest source of scholarship on the Ho-Chunk people. During the early twentieth century, he conducted fieldwork among the Ho-Chunk for his doctoral dissertation in Anthropology at Columbia University. He collected autobiographies from multiple individuals, recorded traditional songs, and described and recorded the ritual of the Winnebago Medicine Dance.

Scholars why rely upon anthropological sources to examine indigenous perspectives face a difficult quandary. Anthropology emerged as an academic discipline in the 1890s and "became the sole disciplinary home for the study of Native Americans."[37] Anthropologists such as Paul Radin, who studied under Franz Boas, focused on the myths, social organization, rituals, and kinship systems of Native communities in an effort to recreate native cultures as "they had once been" while largely ignoring "native experience as it actually was."[38] Boas and his students believed that observations made during the participants fieldwork "could stand in for any moment in the life of the people being studied."[39] In the process they denied Native people agency and helped create "the fiction of Timeless Native Otherness."[40] Yet recognition of these limitations does not invalidate the use of such anthropologic sources by historians. Most likely the Ho-Chunk people who worked with Radin were reticent or selective in what they chose to share, but they revealed a great deal, nonetheless. Radin's research, used in conjunction with other sources, suggests persistence and flexibility of Native world views in the face of multiple pressures. Further, Radin's publications reveal the limits of federal policy, particularly in the latter decades of the nineteenth century, to sever the ties between traditional healers and the Ho-Chunk people.

These sources inform the five chapters that comprise this dissertation. The first examines how disease prompted local removal agents and Congressional leaders to extend federal health care efforts, including smallpox vaccines and physicians' care, during the period of antebellum removal. Congressional leaders and removal agents expressed their actions to provide medical

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[37] Steven Conn, *History's Shadow: Native Americans and Historical Consciousness in the Nineteenth Century* (Chicago: University of Chicago Press, 2004), 155.

[38] Orin Stern, "HERE COME THE ANTHROS (AGAIN): The Strange Marriage of Anthropology and Native America," *Cultural Anthropology* 26, no. 2 (May 2011), 182.

[39] Conn, *History's Shadow*, 195.

[40] Stern, "HERE COMES THE ANTHROS (AGAIN)," 180.

services as “acts of humanity,” but the motivation for the government’s policy was more complex. During a period of religious revivalism that stressed an active Christianity, these efforts helped affirm America as a benevolent nation. But these medical services also had practical, and even insidious, applications. First, they helped facilitate the removal of Native groups to the trans-Mississippi West in spite of these active outbreaks of disease. Secondly, the provision of medical services to Native people had the effect of protecting white citizens from infectious removal parties. These medical services marked the initial efforts of an emergent federal Indian health care system in the 1830s that would continue to grow and expand over the next several decades largely in conjunction with the westward movement of America’s white settler population.

Chapter 2 focuses on the region of the Great Lakes and the Ho-Chunk people during a period of intense conflict. It examines the ways in which federal officials deployed medical care to gain intimate access to Native groups targeted for removal. During the Black Haw War in the summer months of 1832, the U.S. government deployed health care to manipulate intertribal alliances during the regional war between the U.S. military and a band of Sauk and Fox people resisting their removal from the region. The centerpiece of this chapter is the 1832 treaty with the Ho-Chunk that included provisions for medical care in exchange for land cessions. It was the first US – Indian treaty to make that exchange. New forms of colonization required new strategies of adaptation. For the Ho-Chunk, accessing and ensuring their continued access to western medicine, vis a vis physician’s care, emerged as one such adaptation. By examining the events of 1832 between the Ho-Chunk and federal officials, it becomes possible to view the early expansion of this nascent federal Indian health care system from an indigenous perspective.

Chapter 3 focuses on cultural encounters between two different medical systems, disease theories, and healing practices. During the first half of the nineteenth century, these cross-cultural interactions were mutually beneficial for Native peoples and government physicians. The Ho-Chunk allowed for the incorporation the incorporation of outside sources of "power" to address what many Native peoples understood as non-Native diseases (including smallpox). On the other hand, while many physicians dismissed and discredited the religious aspect of traditional medicine ways, they were able to appreciate many of the more practical aspects of these healing traditions, including the application and use of medicinal herbs and plants, which did not differ drastically from the type of medicine practiced by American medical practitioners at the time. These similarities allowed government physicians to incorporate successful therapeutic remedies into their own medical practices. For the most part this flexibility and interaction did not survive into the late nineteenth century.

Chapter 4 examines the rapid expansion of federal Indian health care services in the Pacific Northwest in the 1850s. During that decade, nearly all treaties negotiated contained provisions for medical care, the purchase of medicines, and in some cases, the construction of a reservation hospital. These treaties extended the reach of federal power in the Pacific Northwest and helped establish medical care as an all but standardized part of treaty agreements from that point forward. I argue it is necessary to examine labor relations between Native peoples and white settlers to understand the significant increase in the scale and scope of this emergent medical system.

Chapter 5 examines how changes during the period of Reconstruction extended into the Office of Indian Affairs and, specifically, into matters related to Native health. In 1873, Indian Commissioner Edward P. Smith, a Republican appointee of President Grant, showed interest in

"reconstructing" federal health care services by centralizing, monitoring and directing the activities of these physicians. He oversaw the bureaucratization of the nation's emerging federal Indian health care system into a separate Medical and Educational Division. The bureaucratization of federal Indian health services reveals how state building policies of the Republican party during Reconstruction extended into Indian country. This division became a bureaucratic arm that enabled federal officials to enact policies to serve the interests of an expanding and increasingly aggressive state in the post-Civil War period. Native peoples who saw federal health care services as beneficial to their people in the 1830s, 1840s, and 1850s could not have anticipated how bodily control would become a part of America's colonial project by the late nineteenth century.

By providing federal health care to Native peoples and including medical provisions in treaty documents during the period of antebellum removal, federal officials initiated a process that continued to expand over the middle decades of the nineteenth century. By the start of the Civil War, government physicians were working on reservations from the Central Plains to the Pacific Northwest. While not explicitly seen as a definitive component of the reservation system by government policy makers at the time, these efforts helped make federal responsibility for Native health a permanent aspect of US-Indian relations by the late nineteenth century and a defining feature of the reservation system. For Native peoples, contesting American empire meant resisting control of their bodies and negotiating western medicine and native healing practices. The struggle over health care was part and parcel of a broader struggle for survival and cultural preservation within increasingly deadly environments.

Chapter One

A System Emerges: Cholera, Smallpox, and Medical Aid during Antebellum Removal

This chapter examines how disease prompted local agents and Congressional leaders to provide medical services, including smallpox vaccines and physicians' care, to Native peoples during the early period of antebellum removal. Passage of the *Indian Removal Act* in 1830 provided a victory to the Jackson administration and white southern planters in their desire to dispossess and relocate the states' indigenous peoples. A group of Choctaws, forced to remove from Mississippi to Indian Territory in 1831, were the first of the southeastern tribes to suffer the consequences of the Act. But a smallpox outbreak in the Central Plains in the early winter of 1832 followed shortly thereafter by an outbreak of cholera in the summer of 1832 threatened to upend the process. Congress and local removal agents addressed these two problematic outbreaks by extending federal health care efforts; first by passing the *Indian Vaccination Act*, and second by hiring local physicians to treat members of Choctaw removal parties when they became ill with cholera.

The provision of medical care served the interests of state and national governments. First, medical efforts facilitated the continued removal of indigenous peoples to the trans-Mississippi West despite the outbreak of these two infectious diseases. Second, they helped protect the nation's white citizens from contagious removal parties, particularly those living at the western edges of the nation. Members of Little Rock's Board of Health, for example, expressed their concerns to Choctaw removal agents about the possibility that infectious removal parties would hasten the spread of cholera into their communities. Third, the provision of medical aid to Native people helped ameliorate moral concerns regarding the direction of US-

Indian policy. For reform-minded officials, medical aid was a matter of humanitarian outreach - a Christian response to the suffering of removal parties. During a time of religious revivalism throughout the country many believed that the federal government had a paternalistic duty to provide medical support.

To "encourage rather than retard the spirit of emigration": The Case of the Choctaw

The removal of the Choctaw from Mississippi to designated lands in Indian Territory in the trans-Mississippi West marked the initial stage of a process first envisioned by Thomas Jefferson as a solution to the "Indian problem" following the Louisiana Purchase of 1803. Subsequent administrations supported this idea, although with varying degrees of commitment. President James Monroe proposed a plan to relocate tribes westward in 1824, but his insistence that relocation remain a voluntary act stymied its implementation. President John Quincy Adams also supported voluntary relocation of eastern tribes to the West, but he, more than Monroe, emphatically denounced the idea of implementing this action through force. Adams, described by one historian as "an ardent legalist," recognized that forced removal would require the "unconscionable" violation of treaties.[41] Some groups in the northeast did voluntarily sign removal treaties and relocate to western lands in the trans-Mississippi West (present-day Kansas) under Adams' administration, but this did little to satisfy southeastern planters who looked longingly to the lands of the Cherokee, Choctaw, Chickasaw, Creek, and Seminoles as potential cotton country.

[41] Philip Weeks, *Farewell, My Nation: The American Indian and the United States in the Nineteenth Century* 2nd ed. (Wheeling: Harlan Davidson, Inc., 2001), 36-37.

The greatest conflict over removal took place between the state of Georgia and the Cherokee people. In 1802, the state of Georgia entered into a compact with the United States. In exchange for relinquishing claim to lands along its western border (the future states of Alabama and Mississippi), the federal government promised to initiate the voluntary removal of the state's indigenous peoples, extinguish title to their lands, and facilitate the transfer of Native lands to white Georgians. Implementing this compact proved difficult as the Cherokee chose not to cede their lands. Instead, they implemented a series of reforms, including the adoption of a constitution modeled on the Constitution of the United States, designed to reassert their status as a sovereign people and strengthen rights to their land. These efforts did little to appease white Georgians who were increasingly eager for removal through any means necessary.[42] Demand for cotton was on the rise domestically and internationally, but soil exhaustion threatened output. For planters, Indian lands became an irresistible temptation for economic opportunity during a period of increasing demand for cotton.[43] Frustrations over the federal government's inability to uphold their promise from 1802 led state legislators to act on their own. In the late 1820s, the Georgia State Legislature asserted state sovereignty over the Cherokee nation in an effort to seize Cherokee land. This move placed the future of many other indigenous peoples living on rich agricultural lands in the southeastern United States, including the Creeks, Choctaws, and Choctaws, in jeopardy.

The debate over the removal of the Cherokee people in the 1820s revealed deepening regional divides within the country not only over the status of Native peoples within the American nation, but also over the legal implications of dispossessing Native peoples of lands

[42] John A. Andrews III, *From Revivals to Removal: Jeremiah Evarts, The Cherokee Nation, and the Search for the Soul of America* (Athens: The University of Georgia Press, 1992), 140-144.

[43] Sven Beckert, *Empire of Cotton: A Global History* (New York: Alfred A. Knopf, 2014), 101-108; Anthony F.C. Wallace, *The Long, Bitter Trail* (New York: Hill and Wang, 1993), 3-11.

guaranteed in treaty documents. The Supreme Court helped with some of these reservations. In 1823, the Supreme Court ruled in *Johnson v. McIntosh* that Indians were not owners of their land, but rather were limited to a "right of occupancy."[44] The judgment was clouded with biases carried over from the colonial era that Indians lived as hunter gatherers and therefore did not have the same claims to land ownership as Euro-Americans. The decision also upheld the "Doctrine of Discovery," placing Euro-American claims to ownership of the land over that of the lands' indigenous peoples.

There were also religious arguments against removal. Many Americans who objected to removal were middle-class men and women from the Northeast who were committed to the Christianization of Native peoples and their transformation into agriculturalists. These religious reformers were part of the evangelical movement known as the Second Great Awakening.[45] They rejected or downplayed the Calvinist doctrine of predestination and instead believed that people were moral free agents who could attain moral perfection through their actions on Earth, including the conversion of nonbelievers. Evangelical revivals spurred the creation of an array of benevolent societies including The American Board of Commissioners for Foreign Missions founded in 1810. Members of this organization focused their attentions on the Christianization of Native peoples whose salvation many saw as a "necessary precursor for the millennium."[46]

Evangelicals met with some success in their work among the southeastern tribes, particularly the Choctaw and Cherokee. Thousands of Indians gave testimony to religious conversion. An article published in the *Christian Advocate and Journal of Zion's Herald* in

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[44] *Johnson & Graham's Lessee v. McIntosh*, 21 U.S. 1, 21 (1823).

[45] Alisse Portnoy, *Their Right to Speak: Women's Activism in the Indian and Slave Debates (*Cambridge: Harvard University Press, 2005), 22-23.

[46] John Demos, *The Heathen School: A Story of Hope and Betrayal in the Age of the Early Republic* (New York: Vintage Books, 2014), 60. See also, Andrews, *From Revivals to Removal*, 35-47.

1829 lauded this apparent success. "The revival of religion which is now in progress among the Choctaw Indians," the article detailed, "appears to be more powerful and extensive in its influence, than any thing of the kind which has occurred among the heathen in modern times."[47] These types of publications helped benevolent reformers in the Northeast "feel connected to these missionary successes."[48] Removal to the trans-Mississippi West threatened to upend these efforts of moral uplift and conversion. Religious reformers regard removal as a break from America's commitment as a benevolent nation and the persecution of Native men and women whom they viewed as fellow Christians.[49]

Jackson's election in 1828 signaled a sea change in the debate over Indian removal. Jackson made removal an administrative priority and assembled like-minded men around him who helped craft a particularly compelling argument: removal was "a benevolent policy of the Government" in the best interest for all, including Native peoples themselves. He reassured Congressional leaders that Indian removal to lands west of the Mississippi River, away from contact with whites, would provide them with innumerable benefits. It would "free them from the power of the States…enable them to pursue happiness in their own way," and would help prepare them to become civilized Christians. Although the central issue at stake was land, Jackson described removal as "humane" and "generous." Jackson could also turn to men like Isaac McCoy, a Baptist missionary, and Thomas McKenney, an administration official within the Indian Office committed to missionary efforts among the nation's Indian population, who both viewed removal as a necessary precursor to Christianization. Religious support from men like McKenney and McCoy aided pro-removal politicians.[50] Congress passed *the Indian Removal*

[47] "Revival in the Choctaw Nation*," Christian Advocate and Journal and Zion's Herald*. 4 Dec. 1829.
[48] Portnoy, *Their Right to Speak*, 25.
[49] Ibid, 24; Wallace, *The Long, Bitter Trail*, 35-36.
[50] Andrews, *From Revivals to Removal*, 122-123; 128-129; 213.

Act in May of 1830. The bill empowered the president to exchange lands in the unorganized territory of the trans-Mississippi West for Native lands in the states and territories within the United States. The law guaranteed protection to title of lands exchanged in the West ("forever secure"), just compensation for the value of the lands exchanged (to include improvements made), and, "aid and assistance" for the process of removal and support for the first year. [51] For whites, this act opened lands east of the Mississippi for economic development and exploitation.

The Cherokee nation challenged the legality of the *Indian Removal Act*, but it was dealt a blow by the Supreme Court's decision in *Cherokee Nation v. Georgia* in 1831. The court refused to hear the merits of the case on the premise that the Cherokee people lacked legal standing in the courts to challenge their removal. John Marshall explained:

> The condition of the Indians in relation to the United States is perhaps unlike that of any other two people in existence…The Indians are acknowledged to have an unquestionable, and heretofore an unquestioned, right to the lands they occupy until that right shall be extinguished by a voluntary cession to our Government. It may well be doubted whether those tribes which reside within the acknowledged boundaries of the United States can, with strict accuracy, be denominated foreign nations. They may more correctly, perhaps, be denominated domestic dependent nations. They occupy a territory to which we assert a title independent of their will, which must take effect in point of possession when their right of possession ceases; meanwhile, they are in a state of pupilage. Their relations to the United States resemble that of a ward to his guardian. They look to our Government for protection, rely upon its kindness and its power, appeal to it for relief to their wants, and address the President as their Great Father.[52]

Marshall's opinion in 1831 expanded the racialized thinking applied to *Johnson v. McIntosh* (1823) and further sought to diminish Native sovereignty by defining Native peoples as "domestic dependent nations." In detailing Native peoples as both "wards" and "in a state of pupilage," Marshall further infantilized Native peoples and denied them the same rights and claims to land as their white counterparts. While the Court acknowledged Native sovereignty, at

[51] S. 102. May 28, 1830. 21st Congress 1st Session.
[52] *Cherokee Nation v. Georgia*, 30 U.S. 1, 2 (1831).

least to an extent, in *Worcester v. Georgia* in 1832, these earlier decisions, coupled with Jackson's refusal to adhere to the 1832 decision, ultimately provided a legal backbone to rationalize and legitimize Native dispossession and effect removal of Native peoples to the trans-Mississippi West.

While legal challenges and outright resistance to removal continued among many southeastern tribes, the Jackson administration began implementing removal in 1831 with the Choctaw. In the *Treaty of Dancing Rabbit Creek*, signed in 1830, the Choctaw people ceded all their lands in Mississippi in exchange for lands in the trans-Mississippi West and the guarantee that their sovereignty as a people would be secured.[53] Members of the Jackson administration viewed the removal of the Choctaw as a "test case" for how to proceed with the process more broadly for the tens of thousands of Native peoples living in the southeast.[54] The federal government negotiated many more removal treaties in the subsequent decades and relocated tens of thousands of Native peoples from their ancestral homelands to lands in Indian Territory; some voluntarily and many involuntarily (including the Cherokee and Seminoles).

The Removal Act provided funds to facilitate the removal process, but Congress did not provide clear guidelines on what expenses would be covered or how the process would unfold. Stephen J. Rockwell argues that Jackson intentionally prevented Congress from establishing a system for removal because "immediate removals, even if piecemeal or lacking thorough planning, were preferable to the delays that would be necessary if Indians were to move only in complete groups or if detailed, specific plans were to be worked out for each removal party." As a result, much of the federal government's removal policy was formulated on the ground, largely

[53] *Indian Affairs: Laws and Treaties.* Ed. Charles J. Kappler, Vol 1. (Washington: Government Printing Office, 1904), 310-317.

[54] Rockwell, *Indian Affairs and the Administrative State*, 185.

through trial and error by local removal agents during the early 1830s.[55] Thus, any study on how and why federal Indian health care services expanded in the decades leading up to the Civil War must begin with the experiences of the Choctaw rather than the *Removal Act* itself. It was an active smallpox outbreak in the Central Plains in the winter of 1832 followed shortly by the outbreak of cholera among many Choctaw removal groups that prompted removal agents to lobby Congress to provide funds for vaccinations and the hiring of local physicians on an ad hoc basis to accompany removal parties. It was these decisions that made their way to Congressional discussions on how to proceed with the removal of subsequent groups.

Secretary of War Lewis Cass placed responsibility for overseeing the distribution of federal "aid and assistance" for Choctaw removal with the Commissary General of Subsistence. This made practical sense. The Office of Commissary General of Subsistence was a division of the War Department, which also oversaw the Office of Indian Affairs. The Commissary General's responsibilities included: the purchase of wagons, arrangements for steamboat travel (although many Native peoples objected to this method of transportation), and the planning, purchase, and distribution of food rations. The Office was also responsible for the management of the various individuals involved in implementing removal, including US Army officials, federal removal agents, and private contractors. These were difficult tasks for an Office whose responsibilities prior to Indian Removal were limited to overseeing subsistence of a small standing US Army consisting of approximately seven thousand men. In contrast, the federal government planned to relocate and resettle tens of thousands of Native peoples with some in the administration estimating this number as high as 100,000.[56] Overseeing removal, then,

[55] Ibid, 189.

[56] After the War of 1812, the United States reduced their standing army to roughly 7,000 soldiers. See: Gillet, *The Army Medical Department, 1818-1865*, 27; "Statement showing the whole number of Indians east of the

represented an expansion of the responsibilities of the department well before the complexities of fighting and managing hundreds of thousands of Union soldiers and regiments during the Civil War.

Administrative officials within the Subsistence Office granted broad discretion to local removal agents. Even before the removal process began, Commissary General George Gibson anticipated that agents would need to make decisions on the ground. As Gibson wrote to one of his removal agents:

> My intention is to leave with you a discretion in the application of [removal funds] to other objects connected with the furnishing of provisions to the Indians, such as the employment of persons to aid you in the performance of your duties, for any work or service which may be found indispensable…You will keep your accounts for issues to, and expenditures for, the Choctaw Indians separate from any issues or expenditures not connected with these Indians; and you will take bills and receipts for all purchases, and render your returns and accounts with regularity.[57]

Gibson understood that circumstances could arise that would necessitate flexibility on the ground. This ability to exercise discretion, in practice, meant that Choctaw removal agents had broad power to shape how removal would take place, not only for the Choctaw, but for those who followed.

Officials within the Subsistence Department warned removal agents that it was necessary for Choctaw removal to proceed smoothly as it could establish a precedent for the removal of subsequent groups. After the heated national debate of the 1820s, federal officials, no doubt, feared negative news about Choctaw removal would reignite opposition to Indian removal from religious communities, particularly those in the Northeast. But there were also concerns about

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Mississippi river with whom treaty stipulations have been made for their removal, distinguishing the different tribes," Annual Report (1838), ARCIA, 470. No. 11 lists an estimated removal population of 100,790.

[57] George Gibson to Lieutenant J. R. Stephenson. April 26, 1831. United States. War Department. Subsistence Department, *Correspondence on the Subject of the Emigration of Indians between the 30th November, 1831, and 27th December, 1833* Vol I. (Washington: Duff Green, 1834),11. (hereafter cited as CSEI)

the impact of such news on other target groups. A smooth removal could help compel the removal of other indigenous peoples from their current lands, but news of a disastrous removal experience could create further obstacles. This was especially important because only 5,000 Choctaw were set to remove during the first phase of the process. The Choctaw were roughly 18,000 strong, not including their accompanying slaves, and the possibility for removing the entire population (excluding those who decided to stake their claims by remaining in Mississippi) all at once was an impossibility. Lewis Cass estimated that 5,000 would remove in 1831, 7,000 more in 1832, and 6,000 in 1833. This three phase removal had in fact been secured by the Choctaw people in the 1830 treaty.[58] As J. H. Hook, acting Commissary General of Subsistence wrote in 1831, "Vigilance in the discharge of the duties confided to your assistants, and kindness towards the Indians, are especially recommended, that the reports returned from the first emigrants may encourage rather than retard the spirit of emigration."[59] General George Gibson echoed this caution and warned that every effort should be made so "that no unfavorable impressions may be carried back to their nation that will have the slightest tendency to discourage the emigration of the main body."[60] Unfavorable news, Gibson believed, would no doubt spread to other Choctaw groups awaiting removal and create additional obstacles for the thousands more set to remove.

Many unanticipated challenges emerged during Choctaw removal and local agents had to react quickly to problems such as insufficient food rations, difficult terrains, broken wagons, and even severe weather. In the fall of 1832, less than six days after the wagons arrived for Assistant

[58] Lewis Cass. "Official Documents Accompanying the Message of the President to Both Houses of Congress." *Daily National Intelligencer* [Washington, District of Columbia] 8 Dec. 1832: n.p. *19th Century Newspapers.* Web. 22 Aug. 2018.

[59] J. H. Hook to Captain John B. Clark. June 21, 1831, *CSEI*, 15

[60] George Gibson to Lieutenant J. R. Stephenson. December 27, 1830, *CSEI*, 5-6.

Agent William Colquohoun's removal party, thunderstorms and rained caused impassable roads, broken wagons, and even the collapse of bridge. These obstacles no doubt created poor conditions for the Choctaw people, leaving many exposed and vulnerable to the elements. These conditions were especially difficult for children, and seemed to effect Colquhoun as they were the only deaths noted in his journal. These conditions perhaps explain the attack by a member of the Choctaw party who got hold of a gun and shot at one of the removal agents working alongside Agent Colquhoun.[61] The material realities of relocating thousands of people across hundreds of miles of terrain meant that sickness, disease, deaths, and even births, were part of the lived experiences within removal parties.

The Moral, Political, and Economic Contours of the *Indian Vaccination Act* of 1832

An active smallpox outbreak in the Central Plains emerged as a major obstacle to Choctaw removal in the winter of 1831/1832. The site of the outbreak was the intended relocation site in Indian Territory. Agent Colquhoun warned General Gibson in January:

> This place, but the neglect of the mayor and council, is infected in every direction with the small pox. I left the tavern I was staying at when I last wrote, owing to two cases of small pox in the house. The most perfect reliance may be placed in vaccination, and I beg leave to suggest, as an act of humanity, that an appropriation be made for vaccinating the Choctaw nation, and indeed all those who are liable, from their intercourse with the whites, to take the disease.[62]

Colquoun attributed the spread of smallpox to inaction, including the neglect of distributing of vaccinations. Clearly, he saw the threat of smallpox as ongoing beyond the two victims at the

[61] Journal of Assistant Agent William Colquhoun During the Choctaw Removal. Dec 18, 1832. National Archives RG 75, Letters Received, 1831-1836. War Department. Office of the Commissary General of Subsistence, 1818-1912.

[62] William S. Colquhoun to General George Gibson. January 12, 1832. *CSEI*, 598.

tavern he was visiting during his travels. He argued vaccinations were a matter of "humanity" since the town's political leaders were clearly not up to the task of containing the disease and preventing its further spread.

Colquhoun was not the only agent to appeal to administration officials to provide smallpox vaccines to Native peoples, nor was he the only one to couch such requests in humanitarian language. In January of 1832, John Dougherty, the Indian Agent at Fort Leavenworth, wrote about his experiences witnessing the outbreak of smallpox among the Pawnee in September of 1831. He detailed the high mortality rates among the villages and the inability of members of the tribe to keep up with burials of the dead. But he also detailed the widespread sense of desperation within the tribe. He wrote, "Several of them, on discovering they had taken the disease, put an end to their own existence by stabbing themselves with knives." Others committed desperate acts during the worst stages of the disease. He saw some people "throw themselves into the river" as their bodies raged with fever. Still others, he detailed, who, "when their necks were swollen almost to suffocation, would insert a long, narrow, hard piece of dried buffalo meat into the throat, and rasp it until it streamed with blood."[63] Dougherty most likely included these graphic descriptions to evoke sympathetic responses to the suffering of the Pawnee. But the horrific accounts also highlighted Dougherty's account of of the Otoe, almost all of whom had been vaccinated. He noted that only three Otoe who refused to accept the vaccination succumbed to the disease. By contrasting the Pawnee's pain and suffering with the relative good health of the Otoe, Dougherty sought to garner Congressional action on funding for smallpox vaccinations.[64]

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[63] "Small Pox Among the Indians" *Christian Advocate and Journal and Zion's Herald*. 11 May 1832.

[64] Dougherty most likely sought to appeal to the growing "humanitarian sensibility" within American society which viewed pain and suffering as unacceptable. Karen Haltunnen, "Humanitarianism and the Pornography of Pain in Anglo-American Culture," *The American Historical Review* 100, no. 2 (April 1995), 304.

Baptist Missionary Rev. Isaac McCoy, who worked among the Pottawottamie, similarly wrote to Secretary of War, Lewis Cass, to lobby for a vaccination program and based his argument upon appeals to "humanity."[65] Isaac McCoy's advocacy here is interesting as he had been a strong supporter of Indian removal on the grounds that it was the only means to save the Indians and continue conversion and civilization efforts among them. In fact, McCoy had been awarded for his efforts by the War Department. The Jackson administration shifted money away from religious organizations that had opposed removal, including the American Board of Commissioners for Foreign Missions, and instead provided funds to missionary efforts in the trans-Mississippi West to religious leaders who supported removal, including McCoy.[66] The call for vaccinations was consistent with McCoy's beliefs regarding Indian removal and its ability to support the Christianization of Native groups. Distributing smallpox vaccines could help support the broader civilization mission while simultaneously demonstrating the benevolence of the federal government.

Federal provisions for smallpox vaccines to Native peoples were not entirely without precedent. As early as the mid-eighteenth century, Americans had learned to control the spread of smallpox and utilized the process of inoculation that had developed in Europe during the eighteenth century. While inoculation remained more controversial within the United States (the use of vaccinations would replace the practice of inoculation by the late eighteenth and early nineteenth century), inoculation, and later vaccination, was more widely accepted among the other European powers, including the Spanish, French and English in the middle of the eighteenth century. While not widely practiced and most likely an urban phenomenon, the

[65] Pearson, "Lewis Cass and the Politics of Disease," 10; Andrew C. Isenberg, "Empire of Remedy: Vaccination, Natives, and Narratives in the North American West," *Pacific Historical Review* 86, no. 1 (February 2017), 101.

[66] Andrews, *From Revivals to Removal*, 232-233.

French began administering smallpox inoculations in its French colony in the 1750s. As early as 1807, the French were administering smallpox vaccines to the Five Nations. Inoculation in Spain began in the 1700s and was carried over to their North American empire by 1779. The Dominican friars of the Baja Missions administered vaccines to the Indian populations and documented the relative success of this preventative strategy in the recording of fewer deaths during an epidemic period.[67] Relative to their European counterparts, the British were more resistant to the practice of inoculation among Indians on the North American continent. However, the Hudson Bay Company used vaccination intermittently beginning in 1819 to protect indigenous trading parties, and most likely to reduce the economic disruptions associated with smallpox outbreaks.[68]

There were also domestic precedents for vaccinating Native peoples. In September of 1830, Acting Secretary of War, L. G. Randolph, responded to Assistant Surgeon to the US Army, Doctor Thomas S. Bryant's, request to provide vaccines at his agency. As Randolph wrote, "The Indians Agents are authorized to employ medical aid for the Indians within their agency whenever (in their opinion) it is necessary, and to make such compensation therefor [sic] as may be considered reasonable; but no specific sum per annum can be allowed for such aid."[69] Agents now had the power to provide vaccines to Native groups that they had been tasked to oversee or were in contact with, but the Department of War would not provide funds for such services on a yearly basis. The decision to supply vaccines, then, was left to the individual

[67] Elizabeth A. Fenn, *Pox Americana: The Great Smallpox Epidemic of 1775-82* (New York: Hill and Wang, 2001), 31-43, 155.

[68] Paul Hackett,"Averting Disaster: The Hudson's Bay Company and Smallpox in Western Canada during the Late Eighteenth and Early Nineteenth Centuries," *Bulletin of the History of Medicine* 78, no. 3 (Fall 2004), 594-596.

[69] L. G. Randolph, Acting Secretary of War, to Dr. Thomas S. Bryant, Assistant Surgeon U.S. Army. 23 September 1830 [Cantonment Leavenworth, MO]. NARA, RG 75 M21, Reel 7. *Letters Sent by the Office of Indian Affairs, 1824-1882.*

agents, some of whom responded to smallpox outbreaks by distributing vaccines at their agencies. An article published in February 1831 in the Arkansas Gazette observed that: "The Small Pox is committing great ravages among the Creek Indians. A letter from Fort Mitchell, Alab., says that between 7 and 8,000 of them have been vaccinated at the agency alone." The article gave credit to Dr. Wharton "who, in pursuance of his arduous duty, travelled over a great extent of country; and had not only to encounter the fatigue incidental to such a journey, but, in many instances, to combat the prejudices and superstitions of the natives."[70] Wharton's work reveals an important element not considered in official correspondence; distributing smallpox vaccines depended on Native acceptance of such efforts. Without this collaboration, the distribution of smallpox vaccines among the Creeks in 1831 would not have been possible.

By winter 1832, Congress was taking notice of the ravages of small pox among native peoples, and in April of that year John Bell of Tennessee, chairman of the House Committee on Indian Affairs and author of the *Indian Removal Act*, proposed legislation for a federal vaccination program for Native peoples. Bell's resolution read as follows:

> *1.Resolved*, That the Secretary of War be directed to furnish this House with any information in the Department of War upon the subject of the spread and ravages of the small pox among any of the Indian tribes. 2. *Resolved*, That the Committee on Indian Affairs inquire into the expediency of making provision by law for introducing the practice of vaccination among the Indian tribes.[71]

By March 30, 1832, the Secretary of War's response had arrived and it was shared to members of the House. It detailed letter "information in relation to the existence and ravages of the Small Pox among certain Indian tribes."[72] By April 9, Bell introduced a bill "to provide means for

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[70] "Domestic Items*." Arkansas Gazette* [Little Rock, Arkansas] 1 Feb. 1832: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[71] "Congress*." United States' Telegraph* [Washington, District of Columbia] 28 Mar. 1832: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[72] "Congress." *Globe* [Washington, District of Columbia] 2 Apr. 1832: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

extending the benefits of vaccination among the Indian tribes, as a preventative of the Smallpox" in the House and on April 10th the House approved passage of the bill.[73] Despite opposition from a block of Southern Democrats, the bill eventually passed the Senate and was signed into law.

Scholars have debated the motivation proponents of the Congressional vaccination bill. J. Diane Pearson argues that the program was designed primarily to "enable" and "expedite" Native removal.[74] By contrast, Historian Andrew C. Isenberg suggests that the federal government's foray into the West was much more tenuous. He argues, "Americans' fears and sense of powerlessness in the face of natives, imperial competitors, and smallpox impelled them to vaccinate the Indians of the West."[75] It is true that intent was multilayered and that the vaccination program served multiple agendas. But the timing here is important. Congress passed the vaccination act during the early phase of removal when practical matters on the ground preoccupied the attention of men like Congressman Bell. Congress was interested in facilitating and expediting the removal of the southeastern tribes, including the Choctaw, to Indian Territory.

Smallpox was a horrible disease and many Americans feared exposure. To understand this fear it is necessary to understand the etiology of the disease. Smallpox is a highly infectious and contagious disease that comes in two forms: variola major and variola minor. It is spread from person to person with no animal or insect vector as a transmitter of the disease. The disease progresses in several stages. In the first stage, lasting up to two weeks, the virus is present in the

[73] "Congress." *Boston Courier* [Boston, Massachusetts] 9 Apr. 1832: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018; "Congressional Analysis." *Globe.* [Washington, District of Columbia] 10 Apr. 1832: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[74] Pearson, "Lewis Cass and the Politics of Disease," 9; Beckert, *Empire of Cotton,* 101-108; Wallace, *The Long, Bitter Trail*, 3-11.

[75] Isenberg, "Empire of Remedy," 88.

human host, but the patient does not feel any symptoms of the disease. The second stage is marked by the onset of a high fever, body aches, and nausea followed shortly by a rash. This rash often begins in the mouth before spreading to the arms, legs, hands and feet. The rash then manifests into pustules. After several days, the pustules begin to harden and scab over. The hardened scabs eventually fall off, leaving a scar that remains a visual reminder of the disease for those who survive it. By the fourth week after the onset of symptoms, the patient is free of the disease. Smallpox is contagious beginning with the onset of the rash until the last scab has fallen off the patient, leaving a long period of time when the infection can be spread easily from person to person. This can happen when an infected person coughs or sneezes in the presence of another human. The disease can also remain on clothing and objects for a period of time. This ability to transmit the disease does not end with death; a human corpse can also remain infectious for a certain period.[76]

As early as the mid-18th century, Americans had learned to control the spread of smallpox and utilized the process of inoculation first developed in Europe. Following Edward Jenner's discovery of an effective and safer vaccine in 1798, vaccination became more widely accepted within the U.S.[77] Towns did not hesitate to recommend vaccinations to local residents as soon as news of smallpox appeared. The *Arkansas Gazette* published a notice to residents in 1831:

> This loathsome and dangerous disease, we have good reason to believe, has made it appearance in our town…Vaccination should be immediately resorted to by all who are not secure against the infection. It is a safe and simple remedy – seldom producing more than a very slight indisposition for a day or two, and frequently none at all – and the operation can be performed by any person of ordinary capacity.[78]

[76] Fenn, *Pox Americana*, 13-43.
[77] Ibid, 32-39, 260.
[78] "The Small Poer or Variolaid." *Arkansas Gazette* [Little Rock, Arkansas] 23 Feb. 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

These sentiments were not confined to white settler communities at the periphery. Similar articles appeared in sentiments were shared in Kaskaskia, St. Louis,[79] and Natchez, Mississippi.[80] The *Daily National Intelligencer,* published in Washington, D.C., similarly warned residents that "small pox is spreading on all sides of Georgia – in Arkansas, Tennessee, in South Carolina, in North Carolina, and in some places in this State, the contagion is said to exist. Persons liable to infection should lose no time in being vaccinated."[81] Such recommendations appeared in newspaper across the country and appear to have been a standard response to the threat of smallpox.

Among the dangers posed by smallpox was its economic impact. After reports surfaced that smallpox made its entrance into Chillicothe, Ohio, "the general business of the town" came to halt. To stimulate economic activity and appease fears among local citizens, the local newspaper published the following report, which lauded the Mayor for having launched a vaccination campaign:

> By the timely and commendable precaution taken by the Mayor and council, & the physicians of the place, there is not the remotest prospect of the disease becoming an epidemic even among our own citizens, much less of its attacking from strangers & visitors. We can, therefore, assure our country friends, that they need not anticipate the least fear on account of it; and that they may resume their accustomed intercourse with the town with the most perfect safety.[82]

Addressing smallpox, then, was about more than addressing the physical health of the town's citizens. Encouraging citizens to receive the smallpox vaccine was critical to bodily and economic health.

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[79] "Multiple News Items." *Daily Intelligencer* [Washington, District of Columbia] 21 Mar. 1831: n.p. 19th Century U. S. Newspapers. Web. 22 Aug 2018.

[80] "Multiple News Items." *United States' Telegraph* [Washington, District of Columbia] 30 Mar. 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[81] "Multiple News Items." *United States' Telegraph* [Washington, District of Columbia] 22 Mar. 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[82] "Groundless alarm." *Scioto Gazette* [Chillicothe, Ohio] 9 Feb. 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

But a shift in the discourse surrounding smallpox was taking place in the country. Many argued that vaccination was not simply a choice to be made by individuals. Increasingly, commentators argued that vaccination was a public responsibility. In July of 1831, editors of a newspaper in Macon, Georgia published an article that identified vaccination as the only means to protect towns, cities, and citizens from the disease. They recommended that "Vaccination should be forewith applied, not only in our towns and villages, but in the most secluded parts of the country." They went so far as to identify vaccination as "a duty."[83] Failure to do so, some argued, could be a considered a criminal act. The same article in the Daily Intelligencer that recommended for citizens to get vaccinated added that "Neglect on this subject is criminal."[84]

Because government officials regarded Indians "wards of the state," they assumed that the vaccination of Native peoples was a governmental responsibility. The Agent for the Creeks, who oversaw the distribution of smallpox vaccines in 1831, pointed out that vaccination was necessary not only to prevent disease among Indians, but also to promote health among the residents of Columbus and Macon. As he wrote, "It would be criminal in us to permit the citizens of Georgia to be lulled into a treacherous security."

Congressional leaders who supported passage of the *Indian Vaccination Act* were also motivated by moral conviction, or, at least, by the need to envision removal as an expression of humanitarianism. They communicated their support by lauding the "benevolence" of removal policy and referencing the paternalistic responsibility of the federal government over the nation's "wards." Senator White, a Democrat from Tennessee who had previously supported passage of

[83] "Small Pox." *Macon Telegraph*. [Macon, Georgia] 23 July 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

[84] "Multiple News Items." *United States' Telegraph* [Washington, District of Columbia] 22 Mar. 1831: n.p. 19th Century U.S. Newspapers. Web. 22 Aug. 2018.

the Removal bill, identified Congressional action as a matter of "humanity" that required immediate action. He appealed to the sympathy of senators by referencing evidence that painted a "gloomy picture of the miserable condition of the Indians…dying in such numbers that the dead lay unburied."[85] Invoking sympathy was simply a precursor to inspiring action, the type of activist Christianity championed by Protestant revivalists in the 1830s. [86]

A less obvious, although possible factor to consider in understanding passage of the *Vaccination Act* was the global cholera epidemic that at the time was raging across Europe. At the same time Congressman Bell introduced the *Indian Vaccination Act* to Congress, cholera had struck London with horrible results. New York, Boston, Philadelphia, and Charleston, to name a few, instituted quarantines of goods and passengers from ports in the Baltic and Mediterranean where cholera was active.[87] Boards of health were being formed across the country in preparation for the arrival of the disease. It is unclear whether cholera's impact in Europe and the constant barrage of information regarding the disease in newspapers throughout the country had any bearing on passage of the *Indian Vaccination Act* in May of 1832, but it seems highly likely that some congressman made the connection. The *Vaccination Act* many well have helped to reassure white Americans that the government was looking out for their interests at a time of great uncertainty surrounding cholera's menacing presence across the Atlantic.

Of course, support for the Act was far from unanimous. Democratic support for the bill was not universal. Those who voted against the vaccination bill were largely senators from southern states (ardent removal advocates). For these men, humanitarianism was not an

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[85] *Register of Debates in Congress comprising the Leading Debates and Incidents of the First Session of the Twenty-Second Congress*. Part I, Vol VIII. (Washington: Gales and Seaton, 1833), 795.

[86] Elizabeth B. Clark, "The Sacred Rights of the Weak": Pain, Sympathy, and the Culture of Individual Rights in Antebellum America," *The Journal of American History* 82 (1995), 463-493.

[87] Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1987), 14-15.

administrative priority. Rather, as John Andrews III writes, they saw removal as a "way to dispense with, not relocate, the Indian question."[88]

A "great deal of sickness and mortality among the Choctaw": The Cholera Crisis

In the fall of 1832, Little Rock's Board of Health began preparing for an outbreak of cholera, which seemed imminent by early November. Newspapers had been tracking cholera's movement across Asia and Europe since 1831, informing American citizens nearly daily of it's frightening symptoms (diarrhea, vomiting, fevers, and likely death) and the inability of cities and countries to contain the horror. American citizens had hoped that the disease would remain on the other side of the Atlantic, but reports of cholera in Quebec and Montreal in June and in New York in early July exacerbated their fears.[89]

Little Rock's Board of Health grappled with many unknowns in preparing a plan for their town and its residents. As this was cholera's first entrance onto the North American continent, American physicians had very little knowledge about the disease. The medical community had little to offer in terms of treatments and their recommendations were often contradictory. Some physicians advised the use of cayenne pepper, laudanum, and even calomel to address symptoms of the disease. Calomel, an emetic, would have produced a violent, yet visible response in the patient. Writing in *The Boston Medical and Surgical Journal* in 1831, Dr. John Burne argued against treatment by emetics, including calomel. He believed applications of purgatives aggravated the disease and created "much suffering" in the patients according to his

[88] Andrews, *From Revivals to Removals*, 163. For an overview on the legislative process on passage of the Indian Vaccination Act, see: Pearson, "Lewis Cass and the Politics of Disease," 10-12.

[89] Prior to its arrival to the North American continent, cholera spread from Russia, to Poland, to France, and finally England from the fall of 1831 to the winter of 1832. Rosenberg, *The Cholera Years*, 13-14; 21.

observations. Instead, he recommended "the use of the Tincture of Opium, Castor Oil, and Magnesia, administered in proportions to the exigency of the case." His, he claimed, was a "simple" yet "uniformly successful" treatment that resulted in "curing the disorder without one instance of failure."[90]

Physicians also had very little to offer the American public in the way of preventative measures, and here too their information and recommendations were often contradictory. Many within the medical community believed that cholera was spread through the atmosphere; they assumed that those predisposed to the disease (namely, the intemperate and the filthy) became ill after exposure to bad miasmas or foul odors. Consequently, some doctors recommended the avoidance of ardent spirits and foul odors. But others were convinced that cholera was contagious and recommended quarantines to prevent further spread of the disease. These issues were hotly contested and no doubt contributed to the American public's general distrust of physicians. [91]

Medical and religious assumptions about cholera predisposed residents of Little Rock to see the Choctaw as especially vulnerable to the disease. Popular discourses about what made individuals susceptible to cholera no doubt made residents of Little Rock believe that there was a high probability that such an outbreak would occur among the Choctaw. Both medical and religious discourses relayed narratives about cholera that made racialized groups appear most likely to be predisposed to it. Physicians generally believed that alcohol consumption and filth, were key factors. By disposition, they meant that these factors predisposed a person to becoming ill with the disease. Many equated these habits and "dispositions" as inherent to Native peoples, vestiges of their "savage" habits. Some doctors were beginning to take these racialized

[90] John Burne, M.D. *The Boston Medical and Surgical Journal* 5, no 2 (Tuesday, August 23, 1831), 62.
[91] Rosenberg, *The Cholera Years*, 30-37, 72-73.

arguments further and argue that these "dispositions" were, in fact, biologically rooted in the body and thus fixed. Nevertheless, both placed Native peoples at a higher probability of succumbing to the disease. Religious leaders attributed susceptibility to cholera to Sin.[92] Heathens, then, as most white Americans viewed Native peoples, were almost certainly predisposed to the disease. Little Rock residents as well as other white settler communities and towns at the periphery, then, could look to either medical or religious discourses to affirm their fears about removal Choctaw parties.[93]

The actions of Little Rock's Board of Health suggest that fears ran high among residents. On November 27, 1832, the Board passed a resolution in response to the outbreak of cholera in the interest of "the health and safety of the community." It warned residents "of the danger to which they would be exposed in the event of the appearance of the Cholera" and proceeded to detail a plan to address such appearance. The board informed residents about the construction of a hospital "for the reception and accommodation of all strangers and indigent persons, laboring under the Cholera, or any infectious or contagious disease, demanding the care and attention of this Board." Isolating the sick, the Board hoped, would spare the rest of the community from exposure to this most horrible disease. [94]

But Little Rock residents, along with residents of other towns that bordered Indian territory and lay along the Choctaw emigration route, also feared that removal parties posed a health risk. News of an active cholera outbreak in the region surrounding Vicksburg,

[92] Ibid, 40-54.

[93] This was similarly applied to other racialized groups, including blacks and the Irish, who Americans believed were cholera's "foreordained victims." Ibid, 59.

[94] "Board of Health." *Arkansas Gazette* [Little Rock, Arkansas] 14 Nov 1832: n.p. *19th Century Newspapers*. Web. 22 Aug. 2018.

Mississippi, another site along the intended Choctaw emigration route, appeared as a confirmation of this fear. One year earlier, residents of Little Rock had looked to the Choctaw as a potential source of economic opportunity, but in 1832, amidst the looming threat of the disease, the removal party ignited terror.[95]

The Board let the public know that it was attempted to reroute the removal party in an effort to prevent cholera's entrance into town:

> Whereas, in the event of the Cholera making its appearance among the Emigrating Indians, who are expected to cross the Arkansas, in this vicinity, on their way to the west, their passing through this Town will be calculated, if not spread the disease, at least to produce alarm and excitement among its citizens: Therefore, it is Resolved, That Capt. J. Brown, Principal Disbursing Agent, Choctaw Removal, be respectfully requested, in the event of there being any cases of Cholera among said Emigrating Indians, to select some convenient route, other than the streets of this Town, for their transportation from the place of their landing on the south side of the Arkansas river to the main road leading to the south; and that he be farther requested, to prevent, as far as practicable, straggling parties of said Emigrating Indians from visiting or passing through this Town.[96]

The Board communicated its expectation, both to the town's residents and Choctaw Removal Agent Captain J. Brown, that the federal government had a responsibility to protect town residents from the Choctaw removal parties. This would help diminish opportunities for the Choctaw to spread the disease to town residents, if in fact, as some doctors argued, the disease was contagious. Perhaps the town also feared the economic impact of sick groups of Choctaw travelling nearby. This was the case in Chillicothe in 1831 when news of smallpox brought economic activity to a halt. Little Rock's Board, then, hoped to protect the town's residents from the disease itself and possible the economic impact that could result if news of cholera in the town spread.

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[95]BRING IN ARTICLE

[96] "Board of Health." *Arkansas Gazette* [Little Rock, Arkansas] 14 Nov 1832: n.p. *19th Century Newspapers*. Web. 22 Aug. 2018.

The Commissary General of Subsistence had no plan for the outbreak of cholera among removal Choctaw parties, nor did he provide agents with instructions in the event that cholera struck their camps. Decision-making on the matter of cholera rested entirely with the individual agents. Some attempted to change their route and avoid the region's with active outbreaks of the disease. In October 1832, Agent Colquhoun changed the route of his party in order to avoid the region surrounding Vicksburg. On October 28th, Colquhoun noted that his party ran into "a number of people flying from the cholera." Unfortunately this did not protect his party from the disease. On November 9th he noted that military men in his part had fallen in with the disease.[97] Others made the same decision. Noting the outbreak of cholera near Vicksburg, Agent Simonton chose to change the direction of his party and follow the route of Captain Colquhoun to a town on the Yazoo river that Colquhoun believed "was a healthy, retired place, where it was probable the cholera would not reach us." Unfortunately, this journey was fraught with obstacles and placed Simonton's group in an increasingly precarious position, particularly as it related to their supplies. Despite this detour, Simonton's group ended up in the direct path of a "section of country in which the cholera existed."[98]

Other agents proceeded as planned. Superintendent of Removal, Mr. F. W. Armstrong, was aware of cholera's activity nearby the Choctaw emigration route. On October 21, in a letter sent from Memphis, he wrote:

> Should we escape all will be well, but I confess I fear that we are to encounter the cholera with our Indians; if so, it is not possible for human foresight to calculate what course such a people will take under such circumstances. All the boats now going down from Louisville are suffering great mortality with the ravages of the disease. The Express, seven deaths to this place. The Constitution, two. The Freedom called here yesterday, five deaths since she left the mouth of Tennessee,

[97] Journal of Assistant Agent William Colquhoun During the Choctaw Removal. Dec 18, 1832. National Archives RG 75, Letters Received, 1831-1836. War Department. Office of the Commissary General of Subsistence, 1818-1912.

[98] J. P. Simonton to General George Gibson. April 8, 1833, *CSEI*, 885-886.

> and six now on board down, a lady said to be dying…The disease has heretofore progressed slowly south: the distance, therefore, from this to Louisville may save us, should the general position taken be true that it cannot be communicated.[99]

Despite his awareness of cholera's presence nearby and the deadly toll it was taking, Armstrong's belief that cholera was not communicable influenced his decision to proceed as expected, placing both himself and those under his supervision in harm's way.

Many removal agents used their discretionary power and responded to the 1832 cholera outbreak by hiring local physicians. Divergent rates of pay reflect the lack of centralized administration. Agent Thomas McGee hired physician Samuel M. Southerland for forty-seven days. Southerland charged four dollars per day, for total of $188 dollars, for his services as a physician and an additional three dollars and fifty cents for the purchase of medicines.[100] Removal agent Nathaniel Norwood hired a physician for thirty-two days at two dollars per day for a total cost sixty four dollars.[101] Captain J. Brown paid N. B. Clopton eleven dollars and fifty cents for his services as a physician and for medicines purchased. Brown also hired Dr. Willian P. Reyburn for thirty-one days at ten dollars per day for a total cost of $310. [102] Removal agent Lieutenant S. V. R. Ryan hired a physician at two dollars per day for 64 days, totaling $128 dollars.[103] And removal agent Lieutenant J. P. Simonton hired Silas Brown for his services as a physician for thirty-five days. At ten dollars per day, total expenses equated to $350 dollars.[104]

The decision to hire a physician was not a coordinated act among removal agents. Rather, individual agents overseeing the removal of separate removal parties made the decision to hire local physicians largely of their own volition. Further, it seems that cholera, not other

[99] F. W. Armstrong. October 21, 1832. *CSEI*, 388-389.
[100] Account of Thomas McGee, *CSEI*, 986.
[101] Account of Nathaniel Norwood, *CSEI*, 988.
[102] Account of Captain J. Brown, *CSEI*, 1034, 1054.
[103] Account of Lieutenant S. V. Ryan, *CSEI*, 1060.
[104] Account of Lieutenant J. P. Simonton, *CSEI*, 1102.

instances of illness, provided the impetus for making such a decision. In October of 1832, William Armstrong, Superintendent of Choctaw Removal, detailed in a letter to General George Gibson, the Commissary General of Subsistence, on October 13th, 1832, that despite his belief that medical assistance was necessary during the removal process, he had not yet hired a physician to accompany his removal party. He wrote

> We are using every exertion to emigrate on the most economical plan for the Government. I have as yet employed no physician: to-day an Indian broke his leg, and we will of course have to leave him. We have no medicine but what belongs to private individuals: it is now too late to hear from the department, but I consider it very necessary that we should have medical aid: where there are two thousand Indians, with the wagoners [sic], and those attached to the emigration, at least a physician could have been employed.[105]

Armstrong revealed that his decision not to hire a physician was largely based on financial motivations to oversee the removal of the Choctaw "on the most economic plan." Further, despite instances of medical need, such as the Choctaw who broke his leg, Armstrong saw no motivation for spending additional funds to address medical issues despite his believed that having a physician and medical stores were "very necessary." His reference to the individual stores among individual Choctaw members reveals that they did try to prepare for issues of medical need as they could arise during their removal to the trans-Mississippi West.

Removal agent W. R. Montgomery detailed the experiences that prompted him to hire a physician. As his party approached Vicksburg, the site of the active cholera epidemic, he explained that "cholera made its appearance" among his removal party. "The first subject attacked is since dead," he explained, "five or six other cases, having been taken in time, are doing well; forty or fifty natives are complaining with premonitory." It was not simply that one person had fallen ill; rather, large numbers seemed to fall ill at the same time. He further

[105] William Armstrong to General George Gibson, 13 Oct 1832, *CSEI*, 386-387.

explained that he "did not hesitate" to purchase necessary medical supplies (what he described as "requisite anti-cholera medicines"), "procure medicine attendance," and "order a tent to be made, to serve as an hospital." Montgomery detailed his decision to provide medicines and medical care to his removal party as decisions that "humanity would seem to dictate."[106] This humanitarian appeal was similarly expressed by Agent Simonton. He explained his decision to hire Dr. S. Brown of Jackson, Mississippi as "an act of humanity." It was decision, he believed, "the department would sanction."[107]

Agent William Colquhoun did not wait for cholera to strike his party. Rather, he hired a physician in anticipation of the outbreak. As he explained, "We have been crossing here for two days past with one thousand nine hundred and eight Indians. The prevalence of the cholera at Vicksburg imperiously demanded the employment of a physician to attend the emigrants, and we have therefore called to our aid the services of Doctor Silas Brown, of Jackson, Mississippi. We have agreed to allow him at the rate of six dollars per day."[108] Without clear guidelines on how to proceed, removal agents had to respond to conditions on the ground as they saw best.

The resolution passed by the Little Rock Board of Health makes clear that removal agents also had to contend with the fears of white American communities at the periphery who believed that cholera was contagious. There was no consensus in 1832 on cholera's communicability. Among the medical community there was in fact a heated debate with some believing in the contagious nature of cholera and those opposing this theory supporting an atmospheric (or miasma) theory of the disease. This theory was defined by the belief that cholera was spread through bad air or rotting organic matter that released the disease into the air. The latter theory

[106] W. R. Montgomery to General George Gibson, C. G. S. October 29, 1832. *CSEI*, 769-770.
[107] J. P. Simonton to General George Gibson. April 8, 1833, *CSEI*, 885-886.
[108] William S. Colquhoun and J. P. Simonton to Commissary General of Subsistence. October 25, 1832, *CSEI*, 512.

involved the belief that cholera was contagious. Residents of Little Rock seemed to side with the contagion theorists. This is confirmed by their decision to construct a hospital to quarantine the sick. It is unclear how these agents understood cholera's communicability, but their decisions reflected a fear that cholera was indeed contagious. It is possible then that the decision to hire a physician could also be attributed to their belief that a choleretic removal party could place communities such as Little Rock at risk.

Many agents noted the success of local physicians in stemming the impact of cholera among Choctaw removal groups, but an article published in December of 1832 in the *Daily National Intelligencer* painted a more sobering picture of cholera's toll. The article admitted, "There is now, we believe, no longer any doubt of the existence of the Spasmodic Cholera among the Emigrating Choctaw Indians now proceeding through this Territory to their country West of the Arkansas." In fact, cholera "has made its appearance, we believe, in all parties that we have heard from." The exact number of Choctaw deaths from the disease was not available. But testimony from Dr. Reyburn, whom they noted "has attended in a great number of cases," estimated that "one dies of every four or five that are attacked."[109]

Reimbursement for the expenses for hiring physicians was not consistently applied across all cases. Higher ranking department officials did not always agree with the agents' discretionary decisions. For example, in January 1833, S. T. Cross expressed frustration that reimbursements had not yet been distributed to "several persons, citizens of *Arkansas Territory*, who rendered services to the Government in the removal of a party of Choctaw Indians." He explained that these disbursements were for appointments he viewed as "of minor importance, although absolutely necessary in the removal." This included an interpreter and wagon-master,

[109] "The Emigrating Indians." *Daily National Intelligencer* [Washington, District of Columbia] 19 Dec. 1832: n.p. 19th Century Newspapers. Web. 22 Aug. 2018.

but also importantly a physician. "It is very obvious to any one of the last experience [sic] in the business that the *services* of those persons on whom I conferred appointments could not be dispensed with; and why the then superintendent should reject their claims, is yet for me to understand."[110] From Cross' perspective, the experiences during removal necessitated the hiring of these positions. His difference with the department reveals how critical the independent decisions of individuals working at the periphery were to the origins and development of federal Indian health care policy.

Choctaw removal agents were not the only ones to note the need for medical attendance during the removal process. In a letter to Secretary of War Lewis Cass, James B. Gardiner, Special Agent and Superintendent for the removal of Ohio Indians (including the Ottowas, Shawnees, and Senecas), repeated his request for the appointment of a physician to accompany his removal party to the trans-Mississippi West. He wrote, "our health and safety will certainly require a physician to accompany the emigrants, and a small assortment of medicines and hospital stores." He believed the most practical solution was for the army to supply one of its surgeons. However, if by chance that option was unavailable, he assured Gibson that "a respectable physician can be obtained in this State, for a reasonable compensation." He concluded his request with an appeal to reason. "It seems to my mind a request so reasonable, that I need use no argument in favor of its allowance."[111] Growing consensus was emerging from removal agents that medical aid and the accompaniment of a physician should be a standardized part of the removal process.

The experience of cholera striking Choctaw removal parties left an indelible impression upon local removal agents and federal officials working among Native peoples in the trans-

[110] S. T. Cross to General George Gibson. January 10, 1833, *CSEI*, 631-632.
[111] James B. Gardiner to Lewis Cass. June 23, 1833, *CSEI*, 696.

Mississippi West. In 1834, federal officials cited these experiences to make broader changes to removal policy, particularly when it came to addressing matters related to Native health. In 1834, Congressional leaders debated how to reorganize the Office of Indian Affairs given the expansion of responsibility overseeing the removal of tens of thousands of Native peoples. Input was requested from various officials within the department, including three Indian commissioners appointed by Jackson: Montfort Stokes, the Governor of North Carolina, Henry L. Ellsworth of Hartford, Connecticut, and Reverent John F. Schermerhorn of Utica, New York. While many of their recommendations centered on managing intertribal tensions (including boundary disputes) in the trans-Mississippi West, they used their report as an opportunity to make broader recommendations as it related to health, sickness, and medical care during and immediately following the removal process. Citing the "great deal of sickness and mortality among the Choctaw," the Commissioners recommended that "emigrating parties be accompanied with a physician."[112] Apparently federal officials now saw sickness and disease as inevitable consequences of removal. But the further expansion of medical services was yet to come. These services would come piecemeal as the supply of such medical outreach came to serve federal interests.

Beyond the *Indian Vaccination Act*: extending the "benevolent errand" of vaccination

Smallpox presented an ongoing challenge to Indian agents working in the West. In particular, the continued susceptibility to Native groups to epidemic outbreaks revealed the ongoing need for smallpox vaccines. Local agents continued the work that Congressional

[112] Regulating the Indian Department (To accompany bills H. R. 488, 289, &c. 490). 23rd Congress, 1st Session. Annual Report (1834), *ARCIA*, 83.

leaders initiated in 1832. The *Indian Vaccination Act of 1832* established precedent for federal intervention into matters of Native health, particularly when it came to addressing smallpox outbreaks. However these efforts meant very little to those either excluded from the vaccination program or to those whom vaccinations had not yet been offered.

Beginning around 1837, and lasting for several years, a series of smallpox outbreaks struck the Great Plains and prompted panic among local agents, white settler communities, and Native peoples. It is unclear where the epidemic began, but it was transported to the Upper Missouri in 1837 on board the steamboat *St. Peter's*. The virus then spread throughout the region, devastating the Mandans, Arikiras, Assiniboines, Plains Cree, and Blackfeet.[113]

In 1837, Indian Commissioner T. Hartley Crawford dispatched a physician with the "sole purpose" to distribute smallpox vaccines. He reported in his annual report:

> Every exertion was used to vaccinate as generally as possible, and a physician was despatched [sic] for the sole purpose, under the direction of this office, while the pestilence was at its height. The intrinsic difficulties attending such efforts are apparent; still, it is believed much prevention was effected [sic] and good done. The medical gentleman employed on this benevolent errand vaccinated about 3,000 persons.[114]

Indian Commissioner Thomas Hartley Crawford assessed the damage inflicted by smallpox in his annual report in 1838. He noted that in the Upper Missouri region, "the greatest amount of human life was extinguished." He estimated that "among the Sioux, Mandans, Riccaras [Arikaras], Minnetarees, Assiniboines, and Blackfeet Indians, 17,200 persons sank under the small pox." He admitted that these numbers were far from accurate or complete. In some areas, he acknowledged that "no attempt has been made to count the victims, nor is it possible to

[113] Fenn, *Encounters at the Heart of the World*, 322.
[114] Annual Report (1838), *ARCIA*, 453-454.

reckon them in any of these tribes with accuracy."[115] The Mandans were one of the tribes to suffer the greatest losses. Their population was reduced from 1,600 to 2,000 people in the 1830s to 138 by October of 1837.[116] The agent concluded that the Mandans "[had] been so diminished by the small pox that they will cease to exist as a nation."[117] Major Joshua Pilcher, agent to the Sioux, was quoted as arguing that "the upper-Missouri country, the home to those Native groups most affected by the smallpox outbreak, had been turned "into one great grave yard."[118]

Federal officials working at the periphery used creative means to continue these vaccination efforts. In 1848, smallpox broke out among white settlers and a group of Native peoples north of the Canadian border near Sault Ste. Marie, Michigan. The local Indian agent James Rod reported that he took "immediate steps…to vaccinate all that required vaccination. No case of small pox occurred amongst the Indians living within this sub-agency."[119] Superintendent Henry R. Schoolcraft made the distribution of smallpox vaccines a priority at the Upper Midwest agencies under his supervision. In 1840, he detailed in his annual report that "for vaccination of Indians, $500 have been expended for vaccine matter and vaccinating the bands at various points where the diseases it is intended to neutralize had appeared or was dreaded."[120] These decisions reveal how federal agents working at the periphery largely carried on the work of expanding and deploying federal health care efforts.

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[115] Annual Report (1838), *ARCIA*, 453.

[116] Thornton, *American Indian Holocaust and Survival*, 96.

[117] Annual Report (1838), *ARCIA*, 500.

[118] "Awful Condition of the Indians." *Daily Herald and Gazette*. (Cleveland, Ohio). 14 March 1838: n.p. *19th Century U. S. Newspapers*. Web. 19 Dec. 2017.

[119] James Ord to William A. Richmond, Esq., Acting Superintendent of Indian Affairs. November 7, 1848. Annual Report (1848), *ARCIA*, 558-559.

[120] Henry R. Schoolcraft, Acting Superintendent Indian Affairs, Michigan, to Hon. T. Hartley Crawford, Commissioner of Indian Affairs, Washington. Annual Report (1840), *ARCIA*, 350.

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The outbreak of smallpox in the Central Plains in the early winter of 1832 and the outbreak of cholera in the late summer of 1832 provided the impetus for Congressional leaders and local removal agents to provide medical services to removal groups and to extend vaccinations to thousands of Native peoples, many of whom the government sought to displace. These medical services marked the initial efforts of an emergent federal Indian health care system that would continue to grow and expand over the next several decades largely in accompaniment with the westward movement of the United States' white settler population. Congressional leaders and removal agents understood the provision of medical services as "acts of humanity," one spurred by sympathetic concern for the suffering of the Choctaw and other Native peoples. As this chapter reveals, the motivation for those decisions were more complex. Medical aid to Indians served multiple interests including those of the federal government. During a period of religious revivalism that stressed an active Christianity, such efforts helped to affirm America's collective self-image as a benevolent nation. But medical services also had practical applications. They helped facilitate the continued removal of Native groups to the trans-Mississippi West in spite of active smallpox and cholera outbreaks. They further protected white citizens from infectious removal parties and helped to forestall the potential economic impact associated with these epidemic outbreaks. These medical efforts were intended as temporary measures, but the conditions of removal presented ongoing challenges when it came to matters of health. Actions taken by agents during the 1830s and 1840s helped establish precedent for later intervention by the U.S. Army and federal government officials. These

actions, when viewed collective, reveal the emergence of a nascent federal Indian health care system.

Chapter Two

The System Takes Root: Disease, War, and Medical Diplomacy in the Great Lakes

The nascent federal Indian health care system that emerged during the early stages of antebellum removal in the South simultaneously took root among the tribes of the Great Lakes. Federal health care efforts spread amidst rising tensions among Native peoples, federal officials, and white settlers that erupted into war in the summer of 1832. These tensions began in the 1820s with an influx of settlers to the mineral rich lands of the Ho-Chunk, Sauk, Fox, and Mesquakie people. The federal government employed a variety of strategies to support white settler claims to the region. They increased the military presence in the region through the construction of new forts and sought to intervene in intertribal rivalries and alliances. They used annuity and food distributions to affect decisions to their advantage and deployed military force when they deemed it necessary. The federal government also deployed physicians both formally, through the *1832 Vaccination Act*, and informally, through medical care by army surgeons, to further their policy agenda in the region.

From the perspective of federal officials, including Secretary of War Lewis Cass and Indian Commissioner Elbert Herring, there were enormous benefits to providing medical services to Native peoples of the Great Lakes region. The hope was that physicians would gain intimate access to groups that the government hoped to displace. And during a time of uncertainty as to the outcome of the regional war between the US military and a band of Sauk and Fox people resisting their removal from the region (the Black Hawk War), the government used medical care to manipulate intertribal alliances and to promote neutrality among groups that might have allied with Black Hawk. Even after the conclusion of the Black Hawk War, U.S.

Commissioner John Reynold saw potential in providing medical care to sick members of the Ho-Chunk delegation in order to facilitate land cessions.

New forms of colonization required new strategies of adaptation, and for the Ho-Chunk, accessing and ensuring continued access to western medicine and physician's care emerged as one of those strategies. Since the War of 1812, power dynamics in the Great Lakes had shifted and Native groups were becoming increasingly vulnerable. Many scholars mark the War of 1812 as a significant turning point for Native peoples in this region, as it finalized America's conquest from the Atlantic to the Mississippi River and effectively foreclosed the opportunity for either the British or Native peoples to counter the extension of American hegemony in the region. Historian Richard White, in his study of interactions between the French, British, and Native peoples in the seventeenth and eighteenth centuries and their interactions to find a mutually intelligible world built upon negotiation and mutual accommodation, argues that "[t]he imperial contest over the *pays d'en haut* [Great Lakes region] ended with the War of 1812, and politically the consequence of Indians faded. They could no longer pose a major threat or be a major asset to an empire or republic, and even their economic consequence declined with the fur trade."[121] Historian Lucy Eldersveld similarly argues that the conclusion of the war signaled a shift in U.S. activities and ushered in "a new phase of exploitation, settler colonialism."[122] Land became the central issue as federal officials sought to remove Native peoples from the region to accommodate white settler expansion and state formation. Federal officials warned the Ho-Chunk in 1826: "[O]ur people have settled in the country, and we are anxious that boundaries be established between [us] and the Indian. They were never established with the French or the

[121]White, *Middle Ground*, 517.

[122] Lucy Eldersveld Murphy, *Great Lakes Creoles: A French-Indian Community on the Northern Borderlands, Prairie du Chien, 1750-1860* (Cambridge: Cambridge University Press, 2014), 6.

English…We want to know what is theirs and what is ours."[123] Intended initially as a tool of empire, federal health care efforts exposed the Ho-Chunk to the benefits of accessing and incorporating physicians' care into their communities. Guaranteeing people continued access to that care, secured in treaty negotiations, facilitated Ho-Chunk adaptation to U.S. settler colonial policies in the region, and provided some protection from infectious diseases that accompanied these processes.

"The Indian Problem": US-Indian Policy in 1832

On November 22, Indian Commissioner Elbert Herring published his annual report on the status of Indian Affairs for the year 1832 and reflected on U.S. progress in addressing the "Indian Problem." After noting government expenditures on Indian Services, Herring turned his attention to highlight what he considered some of the positive gains made by the government. He began by noting government work in the construction and maintenance of Indian schools, efforts matched by religious and benevolent associations, that strove to bring "the light of knowledge and the sun of christianity" to the "savage habits and heathenish darkness" of the Indian people. He additionally praised the progress of Indian removal west of the Mississippi, a process shaped by the passage of the 1830 *Indian Removal Act* that included many of Indian tribes in the southeast, including the Cherokee and Creeks. Framed as government intervention in "averting Indian annihilation," Herring focused on the "[k]indred benefits" of removal policy and the

[123] Journal of proceedings at a treaty made and concluded at Butte des Morts on Fox Rivers in the Ter. of Mich. Between Lewis Cass and Thomas L. McKenney, comrs. on the part of the U. S. and the tribes named, Aug. 6-16, 1827. *Ratified treaty no. 148, documents relating to the negotiation of the treaty of August 11, 1827, with the Chippewa, Menominee and Winnebago Indians* (Wasington, D.C.: National Archives, August 11, 1827) http://digital.library.wisc.edu/1711.dl/History.IT1827no148

"liberal provision" of the Government in assisting Indian relocation. report exemplifies the rationalization of policy makers who justified removal and land dispossession as necessary to Native American survival.

In addition to the tribes in the Southern US, Herring also remarked on the progress of the government in concluding treaties with groups in Illinois, Indiana, Missouri and the Michigan Territory following the passage of Congressional acts to extinguish Indian claims in these areas. This included treaties signed by the Ho-Chunk and the Sauk and Fox Indians in September through which the government acquired "valuable territory" and "complete security" for white settlers in the region.[124] Here land emerges as the central tenet driving U.S. Indian Policy in 1832.

Herring's report also highlights the preoccupation shared by policy makers with the "vanishing Indian," a process supposedly associated with the very condition of being "Indian." Commissioner Herring expressed this widespread idea when he resolved "that they must either be left to the fate that was gradually threatening their entire extinction, or that the Government, by some magnanimous act of interposition, should rescue them from approaching destruction, and devise a plan for their preservation and security." Despite his claim that governmental policy was preventing the annihilation of the Native American population, he left room for uncertainty as to whether "the preservation and perpetuity of the Indian race are at all attainable."[125] In effect, Herring and others were able to explain many of the violent and destructive consequences of removal as expressions intrinsic to Native savagery and supposedly inevitable processes.

[124] Elbert Herring, *Report from the Office of Indian Affairs,* Annual Report (1832), *ARCIA*, 159-162.
[125] Ibid, 160, 163.

For all his rhetoric of benevolence, Herring was fully on board with the violent repression of Native peoples when he deemed it necessary. During the summer of 1832, a group of Sauk and Fox Indians, led by noted warrior Black Hawk, resisted their removal from the region. When U.S. officials mobilized militia regiments, Black Hawk and his followers engaged in a series of conflicts, including a successful attack at the Battle of Stillman's Run. The militia gained the upper hand towards the end of July with a series of victories, and a final defeat at the Battle of Bad Axe in early August. Herring condemned what he called the "depredation and atrocious outrage" in the Illinois area. He assured Washington that the "noble" actions of US troops and volunteer militia resulted in the sound defeat of the "hostile Indians," and those who escaped had either been killed or taken prisoner. Herring was pleased that "[t]he chastisement of the aggressing Indians was prompt, decisive, and exemplary, and will have taught a lesson, long to be remembered, that similar offences cannot be practised with impunity."[126]

Herring's 1832 report does more than simply recount some of the major events of U.S.-Indian policy for the year. What Herring describes is the progression and articulation of settler colonialist policies towards Native American peoples and the efforts of US policy makers to justify the acquisition of Indian lands, rationalize the violent responses by the federal government towards "hostile" groups, and articulate the ideological foundation that appropriated Native peoples as objects of U.S. policy. These were not new ideas that emerged in the 1830s to justify Indian removal as a new direction in U.S. Indian policy. As Jodi Byrd argues in *Transit of Empire*, this thinking was intrinsic to the formation and constitution of the United States from the very beginning and "creat[ed] conditions of the possibility of U.S. empire to manifest its

[126] Ibid, 159-162.

intent."[127] This thinking established U.S. intervention into Native lives as not only necessary, due to the "savage" condition of Native peoples, but also mandated as part of the benevolent responsibility of the U.S. government as a Christian and moral nation. This did not require the acknowledgement of responsibility of U.S. policies in contributing to population decline, but instead enhanced the popular conception of Native peoples as a vanishing race and any act by the government as one of benevolent and necessary intervention for the good of Native peoples.

Transformations and Rising Tensions in the Great Lakes Region

The 1832 treaty with the Ho-Chunk - the first treaty to included provisions for a physician in exchange for land cessions – can best be understood within the larger context of transformations and rising tensions in the Great Lakes region. The Green Bay region, defined as the area west of Lake Michigan and enclosed by the Mississippi, Wisconsin-Fox and Rock Rivers, was home to a diverse group of Native peoples, including the Ho-Chunk, the Mesquakie (Fox), Sauk, Sioux, Pottowattomie, Odawa and the Ojibwe farther to the north. For the Ho-Chunk people, life revolved around utilizing the natural resources of the land. In *The Autobiography of a Ho-Chunk Indian*, Sam Blowsnake recalled his experiences growing up in this region during this time:

> After my father had hunted for a considerable time in one place we would move away. My father, mother, older sisters, and older brothers all carried packs on their backs, in which they carried many things. Thus we would pass the time until the spring of the year, and then in the spring we used to move away to live near some stream where father could hunt muskrats, mink, otter, and beaver. In the

[127] Jodi Byrd, *The Transit of Empire: Indigenous Critiques of Colonialism.* (Minneapolis: University of Minnesota Press, 2011): xvii.

> summer we would go back to Black River Falls, Wisconsin. The Indians all returned to that place after they had given their feasts.[128]

Blowsnake described the seasonal migrations that marked Ho-Chunk life in the nineteenth century. In the summer villages, family groups cultivated fields of corn, squash and beans and shared the bounty of their harvests. The Ho-Chunk additionally harvested seasonal berries and gathered wild rice on the shores of the rivers and lakes. The summer, characterized by feasts and ceremonies, provided a collective renewal and affirmation of Ho-Chunk identity before family groups dispersed to their winter camps.[129]

Social organization among the Ho-Chunk was highly regulated; one's place within the tribe was defined by one's gender as well as one's clan membership. As Lucy Eldervseld explains, "[m]en's and women's lives were defined by mutually dependent spheres of activity."[130] Women's work included agricultural management, preparing meat brought back from hunts, preparing meals, sewing clothing, and managing the storage of food. Men's work revolved around hunting and fishing, but extended to diplomacy as well as engaging in war. While men played more prominent roles in tribal politics and diplomacy, women were not excluded from leadership roles and for decisions that affected the community, their "consent" was necessary.[131]

Life was further structured by one's clan membership. Clans largely fell under two larger divisions: "Those-who-are-above," comprised of Thunder, Warrior, Eagle and Pigeon clans, and "Those-who-are-on-earth," comprised of Bear, Buffalo, Deer, Wolf, Elk, Fish, Water Spirit and

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[128] Paul Radin. *The Autobiography of a Winnebago Indian*. New York: Dover Publications, Inc., 1963. Originally published 1920.

[129] Paul Radin, *The Winnebago Tribe* (Lincoln: University of Nebraska Press, 1990), 66-68; Murphy, *Great Lakes Creoles*, 27-29; Murphy, *A Gathering of Rivers*, 22-21-24.

[130] Murphy, *A Gathering of Rivers*, 24.

[131] Ibid, 25.

Snake clans.[132] Both of these larger divisions and clan groupings structured the social organization of the village, marital arrangements, as well as ceremonial and political functions for the tribe as a whole and one's place within the tribe.[133] Each clan not only had its own origin story related to the creation of the Ho-Chunk people, but also its lineage from the clan animal. Clans also passed down important material possessions, including a war bundle, that was at the center of important ceremonies. Four of the clans held important political functions within the tribe: Chiefs were selected from the Thunder clan. Members of the Buffalo clan served as important intermediaries in communicating the chief's messages throughout the villages. The Bear clan played an important "disciplinary" role in the tribe, and members of the Warrior clan played vital roles in war.[134] Unique "friendships" existed between clans and further bound members together into relationships of "mutual service."[135] One did not simply act upon one's own self-interests, but rather understood his or her place in a larger web of social connections.

Since the seventeenth century, the fur trade linked the Ho-Chunk to both local and global markets. The trade had long been a lucrative industry for European empires of the Great Lakes and its success largely depended on Native peoples' participation. Furs provided a means of exchange for clothing, ammunition, tools, weapons and other manufactured goods. These

[132] Michael Schmudlach, "Religion and Clans," *People of the Big Voice: Photographs of Winnebago Families by Charles Van Schaick, 1879-1942* (Madison: Wisconsin Historical Society Press, 2011), 115; Radin, *The Winnebago Tribe*, 142.

[133] "According to the majority of the older people, when the old social organization was still intact, each village was divided into two halves by an imaginary line running due northwest and southeast, the *wangeregi* clans [those who are above] dwelling in one half, with the chief's lodge in the south, and the *manegi* clans [those who are on earth] dwelling in the other half, with the bear or soldier lodge in the north." Radin, *The Winnebago Tribe*, 140; 137-140.

[134] According to scholar Vine Deloria, the bear "seem[s] to appear in almost every tribal heritage as healers or providers of medicine." Vine Deloria Jr, *The World We Used to Live In: Remembering the Powers of the Medicine Men* (Golden, Co.: Fulcrum Publishing, 2006), xxiv.

[135] Radin, *The Winnebago Tribe*, 153.

supplies were especially important to acquire in preparation for winter hunts when food was carefully prepared and stored until the abundance of the spring and summer months.[136]

Native participation in lead mining is less studies than the fur trade, but by the 1820s, lead had largely replaced furs as the main exchange commodity for Native peoples in the region. Native lead mining dates back nearly four thousand years, but in the seventeenth century the French taught Native peoples the process of smelting and molding ore into objects, such as bullets, that made lead a possible commodity to exchange with Europeans as well as other Native groups. In the late eighteenth and early nineteenth centuries, as imperial contests over the region increased, the Ho-Chunk, Mesquakie and Fox increasingly turned to lead, rather than furs, as a means of exchange in local and global markets.[137] While the marketing and distribution of lead and lead products fostered economic autonomy for a short period, it would ultimately place Native Americans on a collision course with American settlers who wanted the advantages of lead mining for themselves.

The Great Lakes region experienced a "lead rush" in the 1820s as white settlers moved into mining areas at the intersection of modern-day Iowa, Illinois and Wisconsin, and sought to stake their claim "in the treasure hunt of the decade."[138] These settlers were part of the massive westward movement of people that began in the 1820s as improved technologies of transportation, including the completion of the Erie Canal in 1825, facilitated the ease of

[136]Native peoples incorporated European traders into extended kinship networks through intermarriage, producing many multi-ethnic families and communities throughout the Great Lakes region. "Native communities insisted on marriage because it created the assurance of mutuality and reciprocal obligations between the spouses' families. If a man refused to take a wife who had kin ties to the community with which he wanted to do business, he was not trusted." Murphy, *A Gathering of Rivers*, 85.

[137] Lucy Eldversveld Murphy argues, "Increasing their mining was one method the Indians used to diversify their commercial production and to reduce their economic vulnerability." Murphy, *A Gathering of Rivers,* 80; 79-84.

[138] Ibid, 102.

movement from the northeast to the Great Lakes and stimulated increasing demands for coal and iron. The mineral rich lands of the Michigan and Wisconsin Territories, with their abundance of coal, copper and lumber, made the region especially attractive to enterprising young men who saw the North American West as a land of opportunity at a time of social and economic instability in the East.[139] The growth of this white settler population resulted in confrontations with the Ho-Chunk. Newcomers had long been successfully incorporated into the dynamics of the region, but these American settlers were not looking to collaborate with Native peoples in the mining and market distribution of lead. Rather, they sought to displace them.

An article in the *Daily National Intelligencer* in 1826 hinted at rising tensions between white miners and the Ho-Chunk people. The article boasted that *"*[t]he miners at the Fever River have been very successful, and their prospects are better than ever. It is said by well informed persons, that there are now 1500 souls at the mines, and that number will be at least doubled the next season." The author of the article acknowledged that "the most important discoveries of ore" were on the lands of the Ho-Chunk people" and that this had resulted in "some difficulty" between white settlers and the Ho-Chunk, who themselves were "actively engaged in working in their own mines." The article attributed the difficulties arising between the two sides to the jealousy of the Ho-Chunk and not the encroachment of white miners onto Native lands. "I think," the author noted, that "some interference on the part of the Government will be

[139] Sean Wilentz. *Chants Democratic: New York City and the Rise of the American Working Class, 1788-1850*. 20th Anniversary edition. (Oxford: Oxford University Press, 2004), 145-216. See also: Thomas Dublin. *Women at Work: The Transformation of Work and Community in Lowell, Massachusetts, 1826-1860*. New York: Columbia University Press, 1981.

necessary"[140] White settler success in establishing economic independence out West would depend, it would seem, on active state intervention in the region.

In 1827, Secretary of War James Barbour responded to calls by settlers for the federal government to rectify the situation and remove the Ho-Chunk people from interfering with the profitable extraction of ore from the region. Barbour suggested that "[t]o obviate any ground of complain, and to meet the wishes of our Western citizens, it is proposed to procure, by purchase, an enlargement of our boundaries in that quarter, so as to embrace the whole of the highly valuable lead mines, said to abound in that region, and for which an appropriation will be hereafter asked."[141] Barbour understood that miners stood at the core of the contestations between the Ho-Chunk and the white miners. He admitted that the grounds upon which Native peoples protested white incursion into the region was the understanding that the miners were intruders "to their lands." Native peoples had extracted lead from the region for thousands of years and these newcomers saw little need to work collaboratively or even respect Native claims to the region. American interests saw Native peoples as obstacles who needed to be removed. Barbour attributed the rising hostilities in the region not to the white settlers who continued to press onto Native lands, but racialized language that sought to differentiate Native peoples from "civilized" whites and contributed to a discourse about Native peoples that sought to undermine their legitimacy as owners of the land as well as their sovereignty. Barbour's report foreshadows how policy makers envisioned resolving these tensions – through the removal of indigenous peoples and the acquisition of their lands.

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[140] Gazette. "A letter from Prairie du Chien, dated Nov. 20, 1826, to a gentleman in Detroit, says." *Daily National Intelligencer* [Washington, District Of Columbia] 12 Apr. 1827: n.p. *19th Century U.S. Newspapers*. Web. 7 Sept. 2017.

[141] James Barbour. Report from the War Department. November 26, 1827.Annual Report (1827), *ARCIA*, 47.

The tensions between the Ho-Chunk and white settlers escalated in 1827 with what came to be known as the Winnebago Uprising. The event began when Ho-Chunk warriors initiated a series of raids against white settlers in retaliation for their encroachment as well as committed depredations against their people. In response, the federal government turned to the Illinois militia and military units to suppress the uprising. Red Bird, who led the raids, acted without permission or authority from the Ho-Chunk leadership, but the federal government held the tribe as a whole responsible and used this as a means to acquire 2.5 million acres of land, including the mineral rich region. Additionally, the treaty signed in 1829 displaced the Rock River band of Ho-Chunk from their homes.[142] The treaty marked the first in a series of treaties that would strip the Ho-Chunk of their homes and require creative adaptations in response to continued removals and relocations over the next few decades. Defeat in 1827 did not eliminate the tribe's anti-American sentiments, but it did highlight the costs of contesting United States expansion in the region through military means.

Five years later, the Ho-Chunk were reluctant to join Black Hawk and his band of followers in the Black Hawk War of 1832. Despite the fact that the Ho-Chunk were intimately tied to the Fox and Sauk people through intermarriage, the lessons from the Uprising in 1827 were still very much in their minds. Some members of the Rock River band of Ho-Chunk, recently displaced from their homes following the defeat of 1827, joined Black Hawk's party, but for the most part, the tribe refused to engage in outright hostilities. The Ho-Chunk played a smart hand throughout the summer months, aiding Black Hawk's band of supporters when they could, but also gaining points with federal officials at important moments. These were strategies

[142] Amy Lonetree. "Visualizing Native Survivance" Encounters with My Winnebago Ancestors in the Family Photographs of Charles Van Schaick." *People of the Big Voice: Photographs of Winnebago Families by Charles Van Schaick, 1879-1942.* (Madison: Wisconsin Historical Society Press, 2011), 16; Jung, *The Black Hawk War of 1832,* 22-50.

employed by the Ho-Chunk to serve the best interests of the tribe.[143] Ho-Chunk leaders were acutely aware of their precarious position in the region, the quest for land by both white settlers and the federal government, the increasing military presence in the region, and the consequences of their defeat in 1827. These events in the summer months of 1832 would impress upon the Ho-Chunk the potential benefit of accessing western medicine as a tool to counter this growing vulnerability. But the cost of maintaining this access would come at a steep price: land.

The Indian Vaccination Act of 1832 in the Great Lakes

It was against this backdrop of war and rising tensions in the Great Lakes that physicians, equipped with large quantities of vaccine material, travelled into Native communities, including the Ho-Chunk, and began administering smallpox vaccines to thousands of Native peoples in the Great Lakes region. These efforts came as a result of Congressional legislation. In May of 1832, Congress passed the Indian Vaccination Act "to provide the means of extending the benefits of vaccination, as a preventative of the small-pox, to the Indian tribes, and thereby, as far as possible, to save them from the destructive ravages of that disease."[144] Congress allotted a sum of $12,000 to provide for private physicians and army surgeons "to convene the Indian tribes in their respective towns, or in such other places and numbers, and at such seasons as shall be most convenient to the Indian population."[145] Financial statements for 1832 reveal that the

[143] Jung, *The Black Hawk War*, 70-78.

[144] May 5, 1832. Twenty-Second Congress, Session 1.

[145] Support and opposition for the Vaccination bill revealed the deep regional divides over federal Indian policy when it was first introduced in the Senate in April of 1832. The fiercest opposition to passage of the vaccination bill came from Southern senators, especially Senator Miller of South Carolina, Senator Buckner of Missouri, and Senator Mangum of North Carolina. Senator Buckner of Missouri voiced his opposition to the bill to a population of persons he term "our natural enemy" when his own requests for "a small appropriation" to fund a hospital in his district had previously been denied. Twenty-Second Congress. Session I.

department spent $7,495.50 for vaccinating the Sioux, Potawatomi, Miami, Ho-Chunk, Menomoni, Sauk and Fox Indians, and Ojibwe (Chippewas) in the North, as well as the Creeks, Cherokees, Seminoles, and Choctaws in the South.[146]

The Indian Vaccination Act of 1832 provided officials in the region with leverage to contain intertribal tensions in the critical summer months of 1832. Although the Indian Vaccination Act had not been conceived in response to the Black Hawk War, I argue that the selection of both enemies as well as potential allies of Black Hawk for inclusion in the program, groups who had not yet signed removal treaties, represented a political move by Secretary of War Lewis Cass to manipulate intertribal alliances in the region and isolate Black Hawk and his band of followers from procuring allies in the ongoing war.[147] Intertribal warfare was increasing, partly as a result of federal policies that were pushing Native peoples into closer contact with one another. One result was the entrenchment of an intertribal alliance system during the 1820s and 1830s that pitted the Ho-Chunk and the Sauks against one another.[148] Thus, a vaccination program that included the Ho-Chunk, the Sioux and the Menominees in 1832, as well as the potential allies of Black Hawk and his faction of Sauk Indians represented a political move by policymakers both as a means to procure potential allies for U.S. forces in an increasingly volatile situation in the region and to keep potential allies of Black Hawk from entering into the conflict.[149]

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[146] "Statement for the Fund for extending the benefits of Vaccination to the Indian tribes" Annual Report (1832*), ARCIA*, 174.

[147] While Isenberg does not account for the Black Hawk War in his assessment of federal motivations in the administering smallpox vaccines in 1832, he does acknowledge that vaccines could, and often were used, as diplomatic tools. Isenberg, "An Empire of Remedy,"106-108.

[148] Jung, *The Black Hawk War of 1832*, 22-50.

[149] In many ways the implementation of the vaccination program mirrored the way federal officials attempted to use rations as leverage to maintain the neutrality of many Native peoples in the region. Ibid, 127-172.

While most scholarship on the *Indian Vaccination Act* focuses on federal intent, it is equally important to examine participation in the vaccination program from an indigenous perspective. Willing participation in the vaccination program by many of these groups did not equate to positive American sentiment, deferment to political pressure, or the acknowledgement of the superiority of white medical practices. In fact, many of these groups, including the Ho-Chunk, harbored anti-American feelings. Instead, the Ho-Chunk, as well as most majority other groups who participated in the program, were acutely aware of the deadly impact of smallpox as well as the potential benefits of the smallpox vaccine. Accessing smallpox vaccines became a survival strategy – a means of countering the costs of American settlement.

For Native Americans, smallpox was the deadliest disease prior to the twentieth century.[150] From the seventeenth century onward, fur traders, missionaries and other Europeans documented what they observed to be the devastating impact of smallpox among the indigenous populations and the high fatality rates that seemed to devastate whole communities in a single outbreak. These mortality rates derived not only from the disease itself, but also from famine and dehydration as very few people were left to care for the sick and maintain crops. Native healing practices, including the use of the sweat bath, as well as European medical practices that relied upon blistering, sweating, fasting, bleeding and vomiting exacerbated the effects of the illness. One factor that determined the vulnerability of a population was prior exposure, and North American population density did not support endemic cases of smallpox that fostered early exposure to the virus and granted immunity for life.[151] But the very nature of the disease and the necessity for a human host meant that Ho-Chunk's participation in the fur trade in the Great

[150] Collin Calloway, *New Worlds for All: Indians, Europeans, and the Remaking of Early America* (Baltimore: Johns Hopkins University Press, 1999): 35.

[151] Fenn, *Pox Americana,* 20-39.

Lakes region and their interconnectedness with other Native communities and European settlers, also significantly shaped the very nature of smallpox among them and the possibility that an outbreak among one village could spell disaster for their own community.

The Ojibwe, a nearby neighbor to the Ho-Chunk and a people with many similarities in their medical traditions and world views, recounted their history with smallpox to Dr. Houghton during his time among them administering the smallpox vaccine. Dr. Houghton's role among the Ojibwe was complex and reveals the dual role physicians played as both agents of the state and sources of healing in their interactions with Native peoples. Dr. Ojibwe distributed vaccines while simultaneously participating in Henry R. Schoolcraft's cartographic and geological survey of the Ojibwe's land. These reports would prove useful to federal efforts to acquire Ojibwe lands and assess its worth prior to treaty negotiations.[152] Houghton learned of the Ojibwe's history with the disease, their understanding of its communicability, as well as the reasons for their "anxious desire" to receive the smallpox vaccine during the early summer months of 1832. In a letter to Commissioner Herring, he detailed the Ojibwe's personal experiences with smallpox dating back to 1750, most likely drawing upon records kept through pictorial representations on rock or birch bark scrolls from which they could recount their detailed history with the disease.[153] For each epidemic outbreak, the Ojibwe noted its origins from interactions with European traders, referred to as "voyageurs" in Houghton's report. These "voyageurs" were most often identified as traders operating in the complex and interconnected fur trade system in the Great Lakes region. From their interactions with these outsiders, smallpox quickly spread among bands in the region with deadly consequences. The "unburied bones" of those lost

[152] Helen Wallin, "Douglass Houghton: Michigan's First State Geologist, 1837-1845." Pamphlet 1 (Geological and Land Management Division, 1966), 5-7.

[153] For information regarding of Ojibwe record keeping practices, see: Joan M. Vastokas, "Ojibwa Pictography: The Origins of Writing and the Rise of Social Complexity," *Ontario Archaeology* No. 75 (2003), 3-16.

to the deadly disease still haunted survivors reminded them of ability of the disease to lay whole villages to waste.

The Ojibwe believed that the transmission of smallpox could be purposeful. In the spring of 1770, a band of Ojibwe complied with a request by the fur trading company at Mackinac to make reparations for previously stolen furs. Upon their departure, they received a cask of liquor and a rolled flag "as a token of friendship." Rather than complying with the order to wait until they "had reached the heart of their own country" to open the cask, the group drank the contents a several days into their journey and became violently ill with what one member of the group recognized as smallpox. It spread rapidly to bands nearby and as Houghton wrote, "not a single band…escaped its ravages." According to Houghton, the Ojibwe firmly believed that the deadly smallpox epidemic "was done for the purpose of punishing them more severely for their offences [sic]."[154]

Nonetheless, the Ojibwe understood the communicability of smallpox and even attempted to quarantine of an infected "voyageur," most likely a trader, in an outbreak around 1802 or 1803. Despite their best efforts, the quarantine was unsuccessful and the virus spread. A military surgeon near the island of St. Joseph was able to step in and proved successful "in checking [smallpox] before the infection became more general."[155] While Houghton did not detail the methods of the fort's surgeon, the Ojibwe understood his actions to have halted its spread and to have saved countless lives in that particular outbreak.[156]

In short, the Ho-Chunk, the Ojibwe, and the many other peoples in the Great Lakes region voluntarily participated in the vaccination program because they understood its value in

[154] "Vaccination," Annual Report (1832), ARCIA, 176.
[155] Ibid.
[156] Theresa M. Schenk, *The Ojibwe Journals of Edmund F. Ely, 1833-1849* ed. Theresa M. Schenk (Lincoln: University of Nebraska Press, 2012), xvii.

staving off a devastating disease. The flexibility of their own medical traditions made their interactions with army surgeons and civilian physicians possible. While federal officials saw the deployment of physicians as a means of furthering their own policy agendas, Native people regarded these same physicians as a source of healing and relief from a dreaded disease. Once the Ho-Chunk and others witnessed the effects of vaccination, they were eager to secure continued access to vaccines.

Averting "the danger of infection": The 1832 cholera epidemic

The *Vaccination Act* did not provide for doctors among the tribes, but it did provide the Ho-Chunk greater access to western medicine. Most notable was the smallpox vaccine itself, one of the most effective preventative measures in the medical arsenal of doctors at the time. Medicine at the mid-nineteenth century was extremely limited in understandings of disease causation and the arsenal available for use by Army physicians was also limited. At the time of the Civil War, physicians were just beginning to recognize the importance of sanitation as a preventative measure, but did not yet have the tools available to respond with effective treatments once disease set in. Available drugs included chloroform and ether for use as anesthetics and quinine to treat malaria. For severely injured limbs, amputation was the standard surgical response. Without an understanding of sterilization, infection often led to high rates of morality among wounded soldiers. Further, the lowly status of medical education and the proliferation of for-profit medical schools contributed to the deficiencies of both doctors and medical education during this time period. The American public remained extremely skeptical of the abilities of doctors and contributed to the lowly status of physicians in comparison to other

sectarian practitioners at this time. The smallpox vaccine was an exception to this larger trend.[157]

New challenges, however, would emerge that required new strategies by both the federal government and the Ho-Chunk in response to the outbreak of cholera among army troops stationed in the region to defeat Black Hawk and his band of followers. Cholera not only threatened the ability of military troops to achieve victory by weakening the army, but making that weakness apparent threatened to encourage neutral tribes to join with Black Hawk and his band of supporters. Managing cholera, then, both within the army regiments and among Native peoples, became another way federal officials, mainly military commanders, sought to deploy medical care in ways that could protect and further the goals of the United States government.

References to cholera were ubiquitous in correspondence between military commanders and government officials during the summer months of 1832. The first warnings of a potential outbreak among army regiments fighting The Black Hawk War emerged in a letter from William C. DeHart in Buffalo to Colonel Abraham Eustis in June 1832. DeHart brought attention to "the great necessity which exists to use every precaution to guard against the introduction of disease, especially the cholera, among the troops under your command." Recommending the use of "Chloride of lime, or Soda" as a disinfecting agent, DeHart foreshadowed cholera's passage to the Illinois region by two companies relocated to the region from Fort Niagara.[158] Cholera was not simply a side story in 1832, in many cases it was the main event.

[157] Kenneth Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1983): 9-20.

[158] William C. DeHart to Colonel Abraham Eustis. June 28, 1832. *Black Hawk War, 1831-1832.* Ed. Ellen M. Whitney (Springfield: Illinois State Historical Society, 1975), 703. (hereafter cited as *BHW*)

The preoccupation with cholera in correspondence between army generals and government officials during the summer months indicates the general terror and apprehension that disease instilled both during The Black Hawk War and the weeks leading up to treaty negotiations. The onset of cholera began with symptoms of "diarrhea, acute spasmodic vomiting, and painful cramps" from which followed dehydration and most likely death within a day.[159] By September 9th, General Winfield Scott noted in a letter to Secretary of War Lewis Cass, that one army surgeon, three lieutenants and 52 enlisted men had succumbed to cholera among his regiments, although the status of the disease among the other regiments was unknown. Scott admitted that the loss of Army Surgeon Coleman and the sickness of two of the three remaining army physicians necessitated the search for three additional physicians, one of whom was taken from private practice. Scott did not detail the experience with cholera as completely hopeless, as he noted a few mild cases were responsive to medicine.[160]

In particular, military officials feared that knowledge of the cholera outbreak among the regiments could significantly influence the participation or neutrality of Native groups, including the Ho-Chunk. Indian Agent George Boyd expressed his anxieties about this possibility in a letter to George B. Porter, Governor of the Territory of Michigan and Superintendant of Indian Affairs, on July 22. He wrote:

> Is it not within human probability, that Indian Tribes, at present lukewarm and indifferent as to the fate of this War – such as the Pottawatattamies [sic] & Ho-Chunkes, both partially allied to the hostile Indians by intermarriages – may not, by witnessing the ravages made by disease among our troops, - at once and to a man, join the Sacs & Foxes, and raise the Tomhawk against us?[161]

[159] Rosenberg, *The Cholera Years*, 2.
[160] Winfield Scott to Lewis Cass. September 9, 1832. *BHW*, 1123-1126.
[161] George Boyd to George B. Porter. July 23d [-25th], 1832. *BHW*, 855.

Anti-American sentiments, particularly among the Ho-Chunk, were well known and real fears existed that Black Hawk's ability to draw more Native groups into the fight as allies could spell disaster for American military forces in the region.

One of the ways military officials sought to protect their regiments and minimize their vulnerability was to regulate the behavior of army soldiers. Army surgeons B. F. Harney, R. M. Coleman, and Samuel B. Smith, M. D. stationed among the army regiments in the Great Lakes region detailed in a letter to the commanding camp officer that the spread of cholera throughout the United States that summer left little hope that they "[would] be exempted from its ravages." Therefore, it was vital to focus attention to containing "its horrors" rather than expecting that the disease could be avoided altogether. They wrote that "[t]he intemperate use of diffusible liquors, is known, from the concurrent testimony of eminent Practitioners of Medicine, to be productive of the most calamitous consequences in a cholera Atmosphere." Since the medical community believed that consuming alcohol increased one's susceptibility to the disease, the surgeons implored officials that "every expedient" measure be taken "to prevent the soldiers from acquing [sic] ardent spirits."[162] General Winfield Scott issued instructions that men "found drunk, or sensibly intoxicated, after the publication of this order, be compelled, as soon as his strength will permit, to dig a grave, at a suitable burying place, large enough for his own reception, as such grave cannot fail soon to be wanted for the drunken man himself, or some drunken companion."[163] General Scott's orders reveal how medical practitioners and army officials sought to confine the spread of cholera by reforming the behaviors of army soldiers. Cholera

[162]Benjamin F. Harney, Richard M. Coleman, and Samuel B. Smith to Daniel Baker. August 18, 1832. *BHW*, 1019-1020.

[163] Winfield Scott: Orders. August 28, 1832. *BHW*: 1068.

had the ability to take down "good & temperate men," but it was those soldiers with moral failings that placed the rest of the regiment at high risk. [164]

While the cholera epidemic devastated regiments in the region, it did not prevent the army from achieving military victory against Black Hawk and his band of followers. Black Hawk's initial victory at Stillman's Run was a bitter pill to swallow. It is difficult to assess to what extent the spread of cholera among the army regiments might have impacted this initial military loss. Fears that neutral groups might join with Black Hawk never materialized. Instead, resolve emerged among troops and militia units to make an example out of Black Hawk both as punishment and as a warning to other tribes in the region.[165]

The violent end of The Black Hawk War was detailed in an article written in *The Galenian* on August 8th. When Black Hawk and his band of followers stationed themselves on the banks of the Mississippi River with intent to cross the following morning, several army regiments assembled nearby for a preemptive strike, or what more aptly could be termed a massacre. According to the article's author, "[w]hen the Indians were driven to the Bank of the Mississippi, some hundreds of men, women and children plunged into the river, and hoped by diving, &c., to escape the bullets of our guns; very few, however, escaped our sharpshooters."[166] It was a brutal end to the conflict that left hundreds of people dead. And, as Indian Commissioner Herring described in his annual report in 1832, it was hoped to impart "a lesson, long to be remembered, that similar offences cannot be practised [sic]with impunity."[167]

[164] Winfield Scott to Lewis Cass. September 1[-2], 1832. *BHW*, 1093.
[165] Jung, *The Black Hawk War*, 119.
[166] "War News from Galena." *The Galenian. (*August 8, 1832). Published in *BHW*, 954-955.
[167] Elbert Herring. Annual Report (1832), ARCIA, 159-162.

"I hope we shall do better than we have done": The 1832 Treaty with the Ho-Chunk

The cholera epidemic played an important role in government efforts to meet with the Ho-Chunk to negotiate a new treaty at the conclusion of hostilities with Black Hawk and his supporters on Rock Island. Earlier attempts to hold the talks were postponed to ensure the safety and health of the Ho-Chunk while cholera was still present in the army camps. The delay is best explained in a letter a soldier wrote to a friend from Rock Island,

> [I]ntirley Ingrossed by terable dises that has Broke out amongst us the Cholr our onse helthey Islan is now a Buring Ground more than one sixt of the troop stashnod hear have died during the last 6 days. the disese is yet Ragin. I am not verrey well. if I do not see you again God Bless you. my account you will find correct I now you will do Justice [sic].[168]

In light of the events surrounding cholera's devastation among army regiments stationed at Rock Island, General Scott delayed meeting the Ho-Chunk "on account of the danger of infection."[169]

Despite the delay and repeated cautions to avoid the spread of the illness to the Ho-Chunk delegates, two members travelling of the Ho-Chunk delegation came down with cholera as they travelled to Rock Island for treaty negotiations. In a letter to Governor John Reynolds, General Winfield Scott surmised that the delegates most likely became ill after travelling aboard the Steamboat U.S. Ho-Chunk. As a precaution, Gen. Scott established a quarantine of the Ho-Chunk camp to contain the possibility of another cholera outbreak and cautioned Agent J. H. Kinzie of the Rock River band to keep his delegation away due to the "possibility" of "a change for the worce [sic]" and to prevent the further spread of the illness. In a letter to General

[168] George Davenport to Russel Farnham. September 2, 1832. *BHW*, 1097.
[169] Winfield Scott to Zachary Taylor. September 5, 1832. *BHW*, 1111.

Alexander McComb on September 10th, the first day planned for talks, General Scott revealed that for the past two months even he was in a state of "[s]ick, or half sick."[170]

General Scott placed Dr. Albion T. Crow in charge of treating the sick delegates. Like Dr. Douglas Houghton and his work among the Ojibwe, Crow's work among the Ho-Chunk delegation further reveals the complex role of physicians who worked among Native peoples in this early period. Crow came to the North American West during the 1820s as part of the migration of white settlers to the lead mining district of the Great Lakes region. He settled in the town of Galena around 1826 and served as one of the towns leading physicians.[171] As many white settlers were noted to have "flocked to Galena for safety" during the Ho-Chunk "scare," Crow was most likely aware of the rising tensions between the Ho-Chunk and white settlers in the region as well as the violent response of the Ho-Chunk. Many white settlers at the time saw themselves as "injured innocents" to Native hostilities.[172] In 1832, Crow was swept up in the regional conflict surrounding Black Hawk's Uprising.. As a veteran of the War of 1812, he answered calls Governor John Reynolds' call to militia service. Crow joined the militia as a private, but the spread of cholera particularly among the army's medical staff, spurred his transfer to serve as army surgeon in General Scott's company.[173]

Crow was well prepared for his visit to the Ho-Chunk camp. He had participated in the administration of smallpox vaccines as part of the Indian Vaccination Act. This prior experience most likely prepared him for his visit to the Ho-Chunk camp. He must have had a positive

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[170] Winfield Scott to Alexander McComb. September 10, 1832. *BHW,* 1130.

[171] Dr. Crow played an important role in both recognizing and mitigating the spread of smallpox in 1829. H.F. Kett & Co. *The History of Jo Daviess County, Illinois: Containing a History of the County, Its Cities, Towns, Etc., a Biographical Directory of Its Citizens, War Record of Its Volunteers In the Late Rebellion ... History of the Northwest, History of Illinois ... Constitution of the United States.* (Chicago: H.F. Kett & co., 1878), 455.

[172] Kett, *The History of Jo Daviess County,* 452-453. Patricia Nelson Limerick, The Legacy of Conquest: The Unbroken Past of the American West (New York: W.W. Norton and Company, 1987), 44.

[173] *BHW,* 1121.

reception within the camp as both delegates showed signs of improvement under his care. These delegates had been removed from their homes and placed in a temporary camp where it is unlikely that they were able to draw upon their traditional medicines. Crow remained at the camp throughout treaty negotiations, perhaps as a precautionary measure or to allow him continued access to his patients. In a sad twist of fate, he lost his thirteen-year old son Henry from cholera the day before the treaty with the Ho-Chunk was signed.[174]

On September 10th, with the Black Haw War officially concluded, Governor Reynolds and General Scott, acting as commissioners of the United States, began their talks with the Ho-Chunk. Cholera had been contained on Rock Island, but it was still a problem in the surrounding areas. It was not until September 12th that the US Commissioners were able to meet with all three delegations of the Ho-Chunk, from Fort Ho-Chunk, Rock River and the Prairie du Chien agencies.[175] The primary objective of the commissioners was the removal of the Ho-Chunk agencies from the current locations to lands west of the Mississippi. Scott believed that the need for removal had become evident as "the white and the red man cannot live together."[176] The rhetoric of the negotiations emphasized the protection of Native peoples from contacts with whites, but the underlying issue was land. The Ho-Chunk resided in a mineral rich area and white settlers and miners wanted complete access to the land as well as the removal of competition from Native peoples in lead mining.

Leader Little Priest, the first speaker during the first council meeting for the Ho-Chunk, acknowledged, "the land now asked for, the whites have wished to get, for a number of years:

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[174] Ibid.

[175] Council with Winnebago from the Fort Winnebago, Rock River, and Prairie du Chien Agencies. First Conference. September 12, 1832. BHW, 1136-1139.

[176] Council with the Winnebago from the Fort Winnebago, Rock River, and Prairie du Chien Agencies. First Conference. September 12, 1832. *BHW,* 1136-1137.

and now their demands can no longer be resisted."[177] Ho-Chunk leaders now sought to ensure that their people had the necessary means and tools to mediate the costs of American expansion in the years to come.

General Scott and Governor Reynolds entered treaty negotiations with general instructions to acquire a large land exchange from the Ho-Chunk, and had wide latitude in what they could offer in exchange. By 1832, policy makers had established a fairly standard process for conducting treaty negotiations. It involved authorization from Congress for a commission to be sent to a specific tribe or groups in order to obtain concessions, establish peace or sometimes to end intertribal conflicts. Congress would appropriate a fund for the commission to use in offer to the Indian tribe and would specify limitations. A sample letter of instruction from Secretary of War John C. Calhoun to Jonathon Jennings, Lewis Cass, and Benjamin Parke before negotiating a treaty with the Delaware and Miami stated the following: "You will designate the time and place the most suitable, in your opinion, for holding the treaty. The terms to be offered depend so much on the whims and tempers of the tribes interested in land, that no particular instructions can be given to you; but the President, reposing full advantageous to the United States is practicable."[178] These instructions reveal how commissioners were given discretion when negotiating with tribal leaders to secure land cessions according to what the Secretary of War described as the "whims and tempers of the tribe." It is safe to assume, then, that the

[177] Ibid.
[178] Vine Deloria Jr. And Raymond J. DeMallie. *Documents of American Indian Diplomacy: Treaties, Agreements, and Conventions, 1775-1979*. Vol 1. (Norman: University of Oklahoma Press, 1999), 177.

provisions detailed in the 1832 treaty represented what the Ho-Chunk both wanted access to and were willing to agree to.[179]

While the Ho-Chunk could not resist federal efforts to acquire their lands in the Green Bay region, they persisted throughout the talks in getting the best deal in exchange, reminding the commissioners of the services provided by the Ho-Chunk in the capture of Black Hawk as well as their earlier participation in rescuing a pair of sisters who had been captured by the Sauks.[180] Knowing that leaving their homes would deprive them of their means of subsistence, Little Priest requested from the Commissioners cattle, ploughs, an agriculturalist, a blacksmith, annuity payments, provisions for removal, and the unsettled reward for the return of the girls. In regards to the request for an agriculturalist and a blacksmith, these requests must be understood as replacing positions that the Ho-Chunk were deprived of during the hostilities in the summer months.[181] While the Commissioners saw these requests in light of the larger colonial project of civilizing the "savage man," which included turning Native peoples into agriculturalists, the Ho-Chunk were ensuring that treaty provisions would be sufficient for the future survival and subsistence of their people during this period of great change.[182] As Little Priest stated, knowing full well the uncertainty of his peoples' future, "I hope we shall do better than we have done."[183]

[179] Ibid, 178. See also: Stan Hoig. *White Man's Paper Trail: Grand Councils and Treaty Making on the Central Plains.* Boulder: University of Colorado Press, 2006; Francis Paul Prucha. *American Indian Treaties: The History of a Political Anomaly.* Berkeley: University of California Press, 1997.

[180] Just as compensation was promised for the capture of Black Hawk, White Crow during talks mentioned that they were promised $2,000 in exchange for the return of the girls. Second Council with Representatives of the Winnebago Nation. *BHW,* 1141.

[181] Second Council with Representatives of the Winnebago Nation. *BHW,* 1142-1144.

[182] In the Third Council with Representatives from the Winnebago Nation on September 14, 1832, General Scott identified education and agriculture as the "two great points which distinguish the civilized man from the savage man." *BHW,* 1148.

[183] The Little Priest, Second Council with the Representatives of the Winnebago Nation. *BHW,* 1142.

The inclusion of the two physicians in the treaty document is more ambiguous and the treaty council meetings recorded by the Commissioners during the treaty negotiations with the Ho-Chunk do not reveal which side proposed the inclusion of the physicians. Physicians are mentioned twice, emerging first when General Scott presented the final treaty outline in the third treaty council. The second time it emerges in the documentary record comes in a response from Caramane, the Lame acknowledging the provision of the two physicians.[184] While it may never be known who suggested the inclusion of physicians' care as part of the deal for land cessions, the events in the spring and summer of 1832 provide the necessary context to understand how these two positions served both the interests of the Ho-Chunk and the US Commissioners at the time, although for different reasons.

For the Ho-Chunk, their experience with army physicians during the implementation of the vaccination program in May followed shortly by the outbreak of a deadly cholera epidemic among the army regiments encamped nearby illuminated the potential benefits of western medicine at an uncertain time. The propulsion to cede their lands in exchange for territory west of the Mississippi might have influenced Ho-Chunk leaders to petition for the inclusion of a physician as part of payments in exchange. The acceptance and sometimes the demands for the benefits associated with western medicine did not necessarily threaten native healing practices at this time. Just as Little Priest's requests for cattle, ploughs, a blacksmith and an agriculturalist did not equate to an acceptance of western practices or even as a demonstration of the positive relationship between the Ho-Chunk and the US, so too can the request for two physicians be understood as a strategy for addressing medical need at a critical moment for the Ho-Chunk.

[184] Third Council with Representatives of the Winnebago Nation. *BHW*, 1149-1150.

The inclusion of two physicians also served the interests of the US Commissioners at this time and it must be considered a possibility that they made the recommendations as a conciliatory offer to hasten the acquisition of Ho-Chunk lands. While the treaty council meetings between the US Commissioners and the Ho-Chunk representatives do not reveal the intentions behind the role of the physicians, the rationalization for the treaty terms becomes clearer in letters written from Gen. Scott and Gov. Reynolds to the Secretary War in the days following the conclusion of the treaty. Land clearly emerges as the most important component of the treaty negotiations as the Commissioners acknowledged that the U.S. government would gain approximately 2,5000,000 acres from the Ho-Chunk. In addition to lands, the Commissioners highlighted the "political advantages" gained by the removal of the Ho-Chunk from Illinois and the Michigan territory. In fact, they admitted in a letter dated September 22 to the Secretary of War that these gains "constituted a leading inducement with the commissioners in agreeing to the stipulations for the benefit of the Ho-Chunk." While they followed this statement with the assertion that they were in control for most of the treaty negotiations, this statement hints at their willingness to comply with terms from the Ho-Chunk to gain access to their lands.[185]

At the end of the September 22nd letter, Reynolds and Scott refer to "conscience" as dictating the "equitable provisions" reached by both sides in the treaty agreement.[186] Similarly to the rhetoric used by Congressional leaders to support passage of the *Indian Vaccination Act*, it becomes possible to view the provision for a physician as a means through which Reynolds and

[185] Gen. W. Scott and Gov. John Reynolds, Comrs., to Sec. of War, Sept. 22, 1832. *Ratified treaty no. 169, documents relating to the negotiation of the treaty of September 15, 1832, with the Winnebago Indians* (Washington, D.C.: National Archives, September 15, 1832). 2014, http://digital.library.wisc.edu/1711.dl/History.IT1832no169.

[186] Ibid.

Scott envisioned resolving the inherent tension of US-Indian policy at this historical juncture. As part of broader societal changes in the early 1830s, appeals to moral conscience became more commonplace as many Americans, as a result of evangelical Protestant revivals that had spread nationally by 1831, began to identify their role as moral agents and the possibility that their actions could change the world in which they lived.[187] It did not require acknowledgement of responsibility for the health crisis among Native groups at this time, but it did help justify policies that deprived Native peoples of their land and ways of life while also embodying the magnanimity of government intervention to help what many believed to be a vanishing people.

While the Ho-Chunk were the first of many treaties negotiated at the end of The Black Hawk War, they were the only one to receive access to care by government physicians in exchange for land cessions. Merely six days after the conclusion of treaty negotiations with the Ho-Chunk, federal commissioners met with the Sauk and Fox. With the defeat, capture, and subsequent massacre of Black Hawk's faction of support during The Black Hawk War, Gov. Reynolds and Gen. Scott met with the faction of Sauk and Foxes that had essentially remained neutral throughout the summer engagements and had in fact already relocated to lands west of the Mississippi voluntarily. Like the Ho-Chunk, this faction of Sauk and Fox Indians participated in the Indian Vaccination most likely as a means of ensuring their continued neutrality during the war. Although many of the same conditions existed in the treaty negotiations between both the Ho-Chunk and the Sauk and Fox Indians, physicians' care did not emerge in treaty negotiations and was not included in the final treaty documents. Therefore, it

[187] Paul E. Johnson, *A Shopkeeper's Millennium: Society and Revivals in Rochester, New York, 1815-1837 (*New York: Hill and Wang, 1978),110-113.

can be concluded, that it was the Ho-Chunk and not the commissioners who should be seen a responsible for including provisions for a physician for the first time in a treaty document.

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Seen from the vantage point of the federal government, the inclusion of a physicians' care in the 1832 Treaty held many advantages. The *Indian Vaccination Act* had not been conceived as a response to the events surrounding Back Hawk's War, but it did serve the interests of the government with respect to the Native groups in the region. Through the provision of medical services, the state gained intimate access to Native peoples it sought to displace from their lands. Vaccines also served as a tool of medical diplomacy. By offering vaccines to potential allies of Black Hawk, the federal government secured the neutrality of Native groups surrounding the Great Lakes. Lastly, it helped secure land cessions from the Ho-Chunk people.

While federal health care efforts over the summer highlighted the potential benefits of physicians' care in serving the interests of the state, I argue that it is also important to recognize what Native peoples, like the Ho-Chunk, had to gain by accepting federal health care services. The Ho-Chunk acknowledged at the start of treaty negotiations that their resistance to removal had been effectively crushed at the conclusion of the Black Hawk War. At the same time, they had positive interactions with government physicians, both as part of the *Vaccination Act* and prior to treaty negotiations. They were convinced of the potential of western medicine to serve as an important source of healing and relief, particularly from smallpox. It also helped that the incorporation of western medicine did not require them to abandon traditional healing practices. The Ho-Chunk could draw upon these medical resources as an accompaniment rather than a

replacement of their traditional practices. In a region long characterized by creative adaptations by Native peoples in response to cultural, social, economic and political change, accessing western medicine and physician's care emerged as another strategy at this critical moment.

Chapter Three

Navigating the System: Native Healers, Government Physicians, and Medical Exchange in the First Half of the Nineteenth Century

The 1832 Treaty with the Ho-Chunk facilitated cultural encounters between two different world views, disease theories, and healing practices. Traditional Native healing practices were embedded in religious thought, derived from their creation stories, and enacted through ceremonies and rituals. Disease and sickness, understood as natural accompaniments to life, could arise from environmental factors, spiritual failings, or even contact with outsiders. While healing could take many forms, the power to heal came from the blessings of the spirits and could be used to treat the ailments of the body as well as the spiritual well-being of the community. [188] Nineteenth century physicians, in contrast, brought a more secularized view of health and healing to their work among Native peoples. It was a worldview in which spiritual beings had no inherent power "as agents of sickness and recovery."[189] Despite the wide range of educational pathways to becoming a physician, these men (as there was no place for women within the medical profession yet) adhered to a system that understood disease as a disruption to the body's equilibrium. The disease did not simply affect one part of the body, but rather impacted the functioning of the body as a whole.[190] It was only through a physician's active intervention that an individual could be restored to health.

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[188] Paul Radin, "The Ritual and Significance of the Winnebago Medicine Dance," *The Journal of American Folk-lore* 24, no. 92 (April, June 1911), 149-208.

[189] James C. Whorton, *Nature Cures: The History of Alternative Medicine in America* (London: Oxford University Press, 2004), 3.

[190] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 38-39.

An examination of the Ho-Chunk, Sauk and Fox, and Ojibwe, who were among the first groups to gain access to physicians' care in exchange for land cessions, reveals that these cross-cultural interactions were mutually beneficial for Native peoples and government physicians in the first half of the nineteenth century. This was in large part due to the flexibility of indigenous world views that allowed for the incorporation of outside sources of "power" to address what many Native peoples understood as non-Native diseases, most notably smallpox. The incorporation of western medicine and physicians' care, including smallpox vaccines, was possible without requiring the abandonment of traditional medicine ways. While many physicians dismissed and discredited the religious aspects of Native medicine ways, they were able to were able to appreciate many of the more practical aspects of these Native healing traditions, including the application and use of medicinal herbs and plants. In fact, government physicians witnessed systems of healing that did not drastically deviate from the type of medicine practiced by American medical practitioners in the first half of the nineteenth century. Similarities allowed government physicians to incorporate successful therapeutic remedies practiced by Native healers into their own medical practices. This ability to navigate between medical worlds that characterized cross cultural interactions between traditional healers and physicians in the first half of the nineteenth century would largely disappear in the latter decades of the nineteenth century.

Native Healing Systems and Medical World Views

Within many Native American tribes across the continent, medicine men and women played central roles within their respected societies; they served as religious figures, as sources

of healing, and sometimes as important political leaders. What set these men and women apart from others was their ability to draw upon the powers of the spiritual world and effectively serve as intermediaries between their people and the spiritual universe. What nineteenth century physicians and outsiders understood as "medicine," Native peoples and their medicine men and women understood as "power." It was their ability to tap into the power associated with the spiritual world that made medicine men and women important figures within their communities not simply when it came to healing the physical ailments of the body, but also importantly the spiritual needs of the community as well.

In times of physical need, Native peoples turned to their medicine men and women to call upon the spirits to restore a sick person's health through medicine, blessings, songs, prayer and ritual. Those identified as medicine men and women understood that their abilities originated from the blessings of the spirits. It was not a position one sought; rather it was a position that one was called upon to fulfill. Oral stories passed down from generation to generation among the Ho-Chunk follow a pattern. After an extended period of fasting, the spirits, often in the form of a human being or animal, would communicate to an individual that he or she had been blessed by them with the power to heal. Oftentimes these communications would come in the course of a dream or vision which signaled that one had been chosen by the spiritual world to become a sacred person. Patrisia Gonzalez in *Red Medicine* explains the significance of dreams and visions within indigenous cultures. She argues they should be considered a "sacred space in which knowledge is received" and were often the means by which indigenous societies organized experiences, diagnosed illness, and interpreted the world.[191] Visions and dreams were

[191] Patrisia Gonzalez, *Red Medicine: Traditional Indigenous Rites of Birthing and Healing* (Tucson: University of Arizona Press, 2012), 171.

sometimes sought periodically to help maintain power and renew one's relationship with the spiritual world.

Thundercloud, and important spiritual and medicinal figure among the Ho-Chunk, provides a case in point. The Ho-Chunk believed that he had lived three lives on Earth. In his previous lives he had been a member of the Medicine Dance and was noted to have "strictly adhered to all its precepts."[192] Like many healers before him and the many more who would come after him, he received knowledge of his healing abilities during a dream in which the spirits communicated to him that he had been marked as a "holy man" among his people. After a period of fasting, Thundercloud relayed the following story to his brother-in-law:

> At the very beginning, those above taught me (the following). A doctor's village existed there; and all the various spirits that lived up in the clouds came after me, and instructed me in what I was to do. In the beginning they taught me, and did the following for me. 'Human, let us try it,' they said to me. There, in the middle of the lodge, lay a dead rottening log, almost completely covered in weeds. There they tried to make me treat (the sick person). Then once he breathed, and all those that were in the lodge also breathed; then the second time he breathed, and all breathed with him; then for the third time he breathed; and then for the fourth time he breathed. As a young man he, the dead log, arose and walked away. After the fourth breathing, he arose and walked away. 'Human, very holy he is,' they said to me.[193]

As the story illuminates, Thundercloud's abilities originated from the spiritual universe. His actions, in this case breathing life into the sick person, was amplified when the spirits acted with him and through him. After receiving this knowledge and experiencing the powers he had been blessed with, the spirits taught him how to be a medicine man to his people. They placed him through a series of tests in order that he might know and see how to use the power he had been given. During this dream he was taught that as long as he made an offering of tobacco to call

[192] Paul Radin, "Personal Reminiscences of a Winnebago Indian," *The Journal of American Folklore* 26, no. 102 (Oct, Dec 1913), 303

[193] Ibid, 306-307.

upon the spirits to aid him in his efforts, there was no feat he could not accomplish, including healing the sick.

Thundercloud's healing abilities and relationship with the spiritual world marked him as an important spiritual and medicinal figure. Many called upon him in times of sickness and suffering to help bring relief and healing to their kin. His brother-in-law stood as witness to his ability as a healer. He not only accompanied Thundercloud as "he went around doctoring," but when he fell ill, Thundercloud drove the sickness away. As Blowsnake explained, "all of the good medicine that exists, all of it, [Thundercloud] knew and used in order to make me well; and thus doing I recovered from my illness. I got well. He (Thundercloud) was holy. From sickness I have been cured, I knew."[194] Equally important was his role as a spiritual resource for his people. He would offer blessings for a successful hunting trip or blessings for a war party. When people needed guidance or needed to communicate to the spiritual world, they looked to him for provide that assistance.

Those identified in the historical record as Ho-Chunk medicine men and women were members of the Medicine Dance, or Medicine Lodge, a secret religious society. As Sam Blowsnake described in his autobiography, "a member of the Medicine Lodge, whether man or woman, was different from a person not belonging to it." One's admission into the society meant that one was no longer "an ordinary person" but rather "a medicine man."[195] Women, as well as men, were able to join both Medicine societies and serve as important medicine figures within their respective tribes, a striking difference between early nineteenth century western medicine and Native medicine ways. While men and women shared equal privileges in many areas of medicine, participation in some medical and religious practices depended on gender.

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[194] Radin, "Personal Reminiscences of a Winnebago Indian," 306-7.
[195] Paul Radin, *The Autobiography of a Winnebago Indian*, 19.

For instance, women were excluded from admission into the sweat lodge and, if the woman was of child-bearing age, she would have been barred from participation until her menstruation had ended. But a woman's gender opened the door to midwifery, a role closed to men.[196]

Members of the Medicine Dance trace the origin of their society, as well as its ceremonies and rituals, to the Hare, an important Ho-Chunk spiritual being. There are many different variations of the origin myth of the Hare, but each tells a similar story. After creating the world, the earth, the animals, and human beings, Earthmaker, or Great Spirit, looked upon his creations with happiness and pride. But the last of his creations, human beings, in a "pitiable" position, were overwhelmed by evil spirits and in need of assistance. Tearfully they looked to Earthmaker for help. In response, Earthmaker sent several beings to earth, but each of them failed to bring relief to human beings. Finally, Earthmaker sent Hare who succeeded where the others had failed. Hare constructed a lodge, assembled the spirits and the first people from the clans and, in one version of the origin myth, spoke to them: "My friends, I have had you come together, for my uncles and aunts had been living a most pitiable life. You are to teach them the life they are to live and which they are to hand down from generation to generation. That is what I ask of you."[197] Through Hare, Earthmaker shared the secrets of the Medicine Dance, the rituals, ceremonies, and construction of the sacred lodge in which the Ho-Chunk people could call upon the spirits to answer their needs.[198]

Admission into the Medicine Dance society was selective and generally occurred in one of two ways. The first and most common pathway for admission into the society involved taking

[196] Murphy, *Great Lakes Creoles*, 167-170.
[197] Radin, *The Winnebago Tribe*, 310.
[198] Paul Radin. *Winnebago Culture as Described by Themselves: The or[i]gin myth of the Medicine Rite; three versions. The historical origins of the medicine rite.* Baltimore: Waverly Press, Inc., 1950.

the place of a deceased relative.[199] It is unclear whether the family or members of the Medicine Lodge made this decision, but the act of replacing a deceased relative ensured that membership largely stayed with one's family group, or clan.[200] The second pathway involved application for admission and helped ensure that no one family group could monopolize the power associated with the Medicine Lodge. Most likely individuals who followed this route received their calling, or blessing, through a vision or dream, and communicated the message they received from the spiritual world when applying for admission into the society or to an elder member of the Medicine Lodge who would recommend admission. As entrance into the society was not simply a privilege but also required great sacrifice in serving the needs of the people, membership was c a great honor and privilege. At the same time, it was not a path that a person would have taken lightly.

The Ho-Chunk understood ailments of the body - disease, injury and sickness - as natural parts of life. They assumed that sickness, like death, was inevitable. The Ho-Chunk believed that disease and sickness could come from multiple sources, including environmental causes and interactions with outsiders. Many Native groups differentiated between Native and non-Native diseases and identified some diseases, including smallpox, as originating from interactions with Euro-Americans. This differentiation between Native and non-Native diseases was similarly shared by other groups, including the Mandans and the Ojibwe. Christopher Vecsey argues that the creation of this category of disease causation should be understood as an adaptation to

[199] Michael Schmudlach,"Religion and Clans," *People of the Big Voice: Photographs of Winnebago Families by Charles Van Schaick, 1879-1942* (Madison: Wisconsin Historical Society Press, 2011), 115.

[200] Radin, *The Winnebago Tribe*, 137-140, 153.

epidemic diseases, including smallpox, that disrupted Native communities and led to crisis to traditional religious systems.[201]

But the Ho-Chunk and other Native peoples also looked to spiritual explanations for disease and sickness. They tended to explain illness by pointing to the failings of a person or a community to live life according to the guidelines passed down by the spirits and communicated through creation stories. In 1846, the Ho-Chunk, faced with the prospect of removing yet again to new lands farther west, sent a delegation to the nation's capital to meet with commissioners to negotiate a new treaty. The Commissioners hoped to wrap up negotiations quickly, a goal equally shared by the Ho-Chunk delegates. Little Hill told the Commissioners that they wanted "to get through with this business, & return soon to our families, many of whom when we left home were sick." In rationalizing the difficult situation facing his people, Little Hill connected the plight of his people to their relationship with the spiritual world and questioned if they were being punished for giving up their ancestral homelands to the United States. As he explained, "The Great Spirit placed [us] in a large fine country – we much fear we have offended the Great Spirit in giving up as much of the good country he gave us as we have already given to our Great Father."[202] While sickness was understood as a natural part of life, it was common practice among the Ho-Chunk to look for spiritual explanations regarding the causes of disease. In this case, Little Hill drew connections between the condition of his people and their failure to live according to the outlines proscribed by the spirits.

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[201] Christopher Vecsey, *Traditional Ojibwa Religion and Its Historical Significance* (Philadelphia: American Philosophical Society, 1983), 154.

[202] Proceedings of the Board of Commissioners appointed by the letter of the Secretary of War, dated 28th Sept. 1846, to treat with the Delegation of Winnebago Indians present in Washington, Thursday October 1, 1846, *Ratified Treaty no. 249, documents relating to the negotiation of the treaty of October 13, 1846, with the Winnebago Indians*. (Washington, D.C.: National Archives, October 13, 1846). http://digital.library.wisc.edu/1711.dl/History.IT1846no249

Much, however, is unknown about Ho-Chunk medical practices in the mid-nineteenth century, including the complexity of their medical ideas, healing systems, and their way of classifying healers. Paul Radin's anthropological work among the Ho-Chunk did not begin until 1908. Thus, it becomes necessary to examine available scholarship from this time period collected and published on other Native groups from the Great Lakes region. Radin made connections between the Ho-Chunk and other Native groups in the Great Lakes, including the Ojibwe (Chippewa), when he published *The Winnebago Tribe* in 1916. As he noted, "The shamanistic and medicinal practices of the Ho-Chunk differ in no respect from those found all over the woodland area and there is consequently no need to discuss them at length."[203] By examining the medical systems and world views of these other groups from nineteenth century, it is possible to offer a more thorough examination of medical practices among Native peoples of the Great Lakes during this period.

The Ojibwe, comprised of multiple bands, were much studied. Observers wrote of their their religious traditions, ceremonies, social organization, interactions with European outsiders, as well as their social and cultural adaptations to French, British and even American imperial ambitions in the Great Lakes region.[204] Observations of the Midewiwin, or Grand Medicine Society, date back to as early as the seventeenth century by French explorers and Jesuit missionaries who observed "jugglers" and "sorcerers" drawing upon the power of the spirits to cure disease.[205]

[203] Radin, The Winnebago Tribe,

[204] See: White, *Middle Ground;* Vecsey, *Traditional Ojibwa Religion and Its Historical Changes.*

[205] Walter James Hoffman examines historical references by La Hontan (1702) and Hennepin (1689) in the introduction to *The Midē'wiwin: Grand Medicine Society of the Ojibway* Reprinted from the 1891 edition. (Honolulu: University Press of the Pacific, 2005), 1-7.

Of particular relevance is anthropologist Walter James Hoffman's work among Ojibwe at the Red Lake and White Earth reservations in Minnesota in the late 1880s. His original intent was to research and record the traditions, ceremonies and "methods of medication" among the Ojibwe. In collecting information about the Midewiwin, or the Grand Medicine Society, Hoffman relied upon interviews with chief Mide priests and birch bark records whose original owners were members of the Midewiwin. One of the birch bark records belonged to an Ojibwe man named Skwēkō′mĭk who came into possession of the scroll after the passing of his father-in-law. The scroll had been passed down many times since, but the original owner, according to Skwēkō′mĭk, was the Grand Midē′ priest at La Pointe, Wisconsin. Hoffman understood the significance of this record and explained its continued value among members of the Midē′wiwin:

> The present owner of this record has for many years used it in the preliminary instruction of candidates. Its value in this respect is very great, as it presents to the Indian a pictorial resume of the traditional history of the origin of the Midē′wiwin, the positions occupied by the various guardian man′idos in the several degrees, and the order of procedure in study and progress of the candidate.[206]

Hoffman also gained access to another birch bark record dated to 1830 that belonged to the chief Mide priest at Milles Lacs. Despite Hoffman's preoccupation to present an assessment of these traditions in their most "primitive" form, his work provides many important insights into Ojibwe medicine ways in the mid-nineteenth century.

Hoffman's field work among the Ojibwe at the Red Lake and White Earth reservations was part of a movement in the field of anthropology that scholars term salvage ethnography. This type of work was premised upon the basic understanding that Indians, in their pre-contact, "primitive" forms, were disappearing. Therefore, work like Hoffman's was both necessary as

[206] Hoffman, *The Midē'wiwin*, 17.

well as urgent from his perspective, since these practices were assumed to be fated for extinction. However, those who participated willingly with Hoffman were themselves practicing a type of salvage ethnography. In the late 1880s, Hoffman detailed the divisions present among the Ojibwe on White Earth, particularly in the southern part of the reservation. Hoffman wrote that "many of these people have adopted civilized pursuits" while to the north there was much greater adherence to "traditional customs and beliefs."[207] Perhaps the Mide priests who shared many intimate details with Hoffman of their religious and medicinal practices were themselves worried that their traditional way of life were also in the process of disappearing.

The work of Dr. James Walker among the Oglalas (Lakota Sioux) offers a fruitful point for comparison to understand Native participation in this type of ethnographic field. The Oglala medicine men formally initiated Dr. Walker, who worked among them as a physician at the Pine Ridge Reservation beginning in the 1890s, into their secret religious society. Walker sought assistance from the medicine men in tackling the increased rates of sickness and suffering, including tuberculosis, within the reservation population. In response, the traditional medicine men of the tribe began sharing with him the foundations of Lakota belief and ritual. He recorded their reasons for doing so: "We will do this so that you may know how to be the medicine man for the people." They began his admission into the Buffalo Society in 1905 after one of the holy men sought permission to divulge this information to Dr. Walker in a vision quest. The decision was made knowing fully well Walker's complex role among them and the assimilation policy of the federal government at the time. However, admitting Dr. Walker into their religious society was also made in the interest of the tribe. They expressed their hope that his recordings of what

[207] Ibid, *2*.

they revealed to him could serve as a spiritual resource for their people in the future.[208] While we cannot know for certain why the Mide priests provided intimate access to Hoffman, it is more than likely that their participation was not only for Hoffman's benefit.

While Hoffman focused his attention on the Midewiwin, his work nonetheless provides a window onto the many different types of individuals who practiced medicine in the late nineteenth century among the Ojibwe at Red Lake and White Earth. Federal records from this period referred to all healers as "medicine men" in the historical record and ignored the complex medicinal system and many different classifications of healers that were a part of it. Hoffman identified three classes of healers among the Ojibwe: the Wabeno, the Jessakid, and, most important, the Mide. Wabeno, also termed "men of the dawn" and "fire-handler[s]," practiced what Hoffman termed "medical magic." People came to the Wabeno for love powders or hunting medicines. The Wabeno performed their ceremonies at night and often revealed their powers through public demonstrations, such as handling fire or burning water without injury. Hoffman identified these men as "pretenders" and cited a source that referred to these individuals as corrupted practitioners of the Midewiwin.[209] The Jessakid were individuals who held powers of prophecy and were known as "revealer[s] of hidden truths." In regards to practicing medicine, the Jessakid could identify if a patient was possessed, as a source of disease. While the Wabeno and Jessakid practiced their medical art as individuals, Hoffman acknowledged that they could apply for admission into the Midewiwin.

[208] James Walker, *Lakota Belief and Ritual.* Eds. Raymond J. DeMallie and Elaine A. Jahner. (Lincoln: University of Nebraska Press, 1980), 3-7.

[209] Hoffman, *The Midē'wiwin*, 8-9.

The most important healers among the Ojibwe were members of the Midewiwin. Much like the Ho-Chunk, members of the Midewiwin trace their origin to their creation stories.[210] There are many similarities in the origin story of the Midewiwin among the Ojibwe and the Medicine Dance of the Ho-Chunk. Both groups traced their knowledge of healing to the Great Spirit, or for the Ho-Chunk, Earthmaker. In one telling of the origin myth, "Kītshi Mani′dō [the Great Spirit] saw that his people on earth were without the means of protecting themselves against disease and death, so he sent Mi′nabō′zho [the Great Rabbit] to give them the sacred gift."[211] The Great Rabbit, similar to the Hare in Ho-Chunk origin stories, was contemplating how to communicate with human beings the sacred knowledge from the Great Spirit when the Otter (Ni′gĭk) appeared in a body of water. He appeared first in the West, then the North, then the East, and finally the West again, before appearing on an island in the center of the water.[212] The Great Rabbit entrusted Otter with the sacred knowledge he had gained from the Great Spirit, and tasked him to communicate knowledge of the Midewiwin to the human beings. Otter passed on this knowledge as well as a series of sacred instruments - a sacred rattle, drum and shells - that human beings would need to communicate with the spirit world.

Admission into the Midewiwin granted a person access to the ceremonies, songs, sacred instruments and power to communicate with the spiritual world. Knowledge of the ceremonies and rituals associated with the varying degrees of membership among the Mide' came with age

[210] Walter James Hoffman described the Midē′wiwin as "based to a considerable extent upon traditions pertaining to the cosmogony and genesis and to the thoughtful consideration by the Good Spirit for the Indian." In the 1880s, anthropologist Walter James Hoffman recorded his observations of the ceremonies associated with the Medwiwin during his time among the Ojibwe at White Earth, Minnesota. Despite Hoffman's preoccupation to present an assessment of these traditions in their most "primitive" form, his work nonetheless provides many important insights into Ojibwe medicine ways that can shed light on the type of world in which the medicine men and women of the Great Lakes existed. Hoffman, *The Midē'wiwin*, 14.

[211] This version of the origin myth came from Sikas′sigĕ`s, a Mide' member of the second degree at Mille Lacs who was first admitted into the Midē′wiwin at 10 years of age in 1830. Ibid, 27.

[212] Ibid, 18.

and time, akin to a period of apprenticeship under a master/expert. A person was not entitled to initiation into the higher degrees of the Mide. Rather, one had to earn it through displays of their skill. According to Hoffman, candidates had to wait an extended period, sometimes years, before they "were eligible for promotion." This promotion was tied to the ability of the candidate to make an offering of "equal in value and quantity four times the amount paid at the first initiation." One's "success," observed by Hoffman, depended on one's ability "to possess the required articles" of skins, robes and blankets. This success was dependent upon an individuals' "own exertions" and most likely was a measure of their success as a healer. The greater the number of goods accumulated in exchange for services rendered by a Mide priest, the more likely that individual had earned the "success" necessary for greater knowledge of the sacred mysteries of the Midewiwin. [213]

When it came to curing disease, members of the Midewiwin each played a specified role in terms of diagnosing the cause of disease, applying the proper herbal remedy, or even leading certain rituals and ceremonies to either prevent disease or help cure disease. One group of specialists were herbalists and they understood "the mysterious properties of a variety of plants, herbs, roots, and berries" and knew how to apply them as remedies. Hoffman noted that many of the members of the Midewiwin who practiced as herbalists were women.[214]

[213] Ibid, 109.
[214] Ibid, 11.

Navigating Medical Worlds

These systems of healing did not foreclose opportunities to access and incorporate outside sources of power. Native peoples of the Great Lakes region welcomed the smallpox vaccine for a disease that they understood as non-Native in origin, a "white man's disease." Native sicknesses, understood as originating from a disharmony between human beings and the spiritual universe, could only be cured through the work of a Native healer.[215] White man's diseases, however, needed to be treated with white man's medicine. They regarded smallpox, for instance, as a disease that their own traditional healing systems were unable to combat precisely because it originated with Europeans.

An outbreak of smallpox among the Ho-Chunk in Blue Earth, Minnesota in 1860 provides a case in point to these types of interactions. A. Coleman, physician to the Ho-Chunk in 1860, remarked in his annual report on the strong ties between Ho-Chunk religious and medical practices. He noted that "the views and practices of the Indians in regard to the practice of medicine, have been passed down to them by a succession of generations, and are not only intimately interwoven with their religion, but also with their government."[216] The disruptions of removal did not seem to lessen the influence of the medicine men; rather, as Coleman observed, they remained a central part of nearly all aspects of community life. He noted that the Ho-Chunk people place primacy on their traditional healers, the men and women of the Medicine Dance, for spiritual and physical healing. When it came to smallpox, however, they did not hesitate to draw upon the services they secured in the 1832 treaty. In fact, it is notable that smallpox struck the Ho-Chunk at their new reservation in Blue Earth, Minnesota since the group had access to

[215] William Powers, *Oglala Religion* (Lincoln: University of Nebraska Press, 1975): 129-130.
[216] September 25, 1860. Annual Report (1860), ARCIA, 77.

physicians' care and vaccines, which included access to smallpox vaccines, as early 1832. The agency physician surmised that "[smallpox] was introduced among them from Wisconsin" among those groups who were forcibly removed and relocated to Blue Earth after a new treaty was negotiated in 1858.[217]

The Ho-Chunk peoples' interactions with Dr. Coleman during the 1860 smallpox epidemic reveals how they navigated between medical worlds to address matters of health and healing largely on their own terms. Significantly, the Ho-Chunk notified Dr. Coleman when smallpox struck their community. "Their knowledge of its fatality," he admitted, "induced them to seek medical assistance, much more in this than any other disease with which they have been afflicted." Coleman immediately set to work stemming the outbreak by instituting a quarantine of the sick, to confine the disease, and then by doing his best to stop its further spread. This included instructing members to destroy all items that had been in contact with an infected person, especially clothing, a practice that in the end proved effective although quite costly according to Coleman. Next, he set to work vaccinating members of the group. Although two hundred and sixty people died during the outbreak, the willing participation and engagement with Dr. Coleman reveals how the Ho-Chunk utilized his services when they identified a need to do so.

Native groups that resisted opening their communities to white people and cultural institutions made an exception for physicians. One such example is the Sauk and Fox people. In 1851 the agent for the Sauk and Fox Indians noted that "at the request of the chiefs a physician was appointed to them" in response to an outbreak of smallpox among the villages.[218] The funds

[217] A. Coleman, Physician. Winnebago Agency, Minnesota, September 25, 1860. Annual Report (1860), ARCIA, 77.

[218] Annual Report (1851), ARCIA, 66.

to fulfill such a request were part of a treaty the Sauk and Fox people negotiated in 1842 with the federal government. In exchange for land cessions, federal officials created a fund of $30,000 "to be expended by the chiefs, with the approbation of the agent, for national and charitable purposes among their people." This included, but was not limited to, funds for "employing physicians for the sick."[219] The chiefs' request by the chiefs for access to a physician stood in stark contrast to the position of the Sauk and Fox with respect to other white cultural practices and institutions. This included a strong opposition to schools, missions, and even the construction of housing within the agency. According to the agent for those tribes, they believed "that so soon as they permit houses of any description to be built for the use of their tribe, that the extraordinary charm which they suppose to be in their medicine bags and medicine lodge will cease, and that the religion of the white man will be implanted in their stead."[220] The medicine ways of the Sauk and Fox people were embedded in their religious identity and their relationship to the spiritual world. What the agent referred to as "charm," they understood as power. Medicine bundles, or "bags" as described by the agent, were vessels of this power. The Sauk and Fox saw medicinal bundles as sacred objects. They believed the transfer of those bundles had the effect of passing that power from one generation of traditional healers to the next.[221] Any outside sources that could disrupt this power, particularly as it related to the incorporation of Christianity into their communities, was vehemently opposed.

For Native peoples, medicinal practices and religion were intertwined. They regarded Christian missionary efforts as potentially threatening to their healing powers. A story recorded during the 1850s by the German historian and scientist Johann George Kohl, during a trip to

[219] Treaty with the Sauk and Fox Indians, 1842. Kappler, *Indian Treaties*, 546-547.
[220] Annual Report (1851), ARCIA, 66.
[221] For a description of the spiritual power and importance of medicinal bundles to doctors, see: James R. Murie, *Ceremonies of the Pawnee*. Ed. Douglas R. Parks. (Lincoln: University of Nebraska Press, 1981), 167-176.

Lake Superior, illustrates the point. Kohl collected stories from various bands of Ojibwe Indians. In one such meeting, Khon recorded the story of the first man created by Kitchi-Manitou [the Great Spirit] and his experience as a medicine man:

> One day…the [first] man found a book lying under a tree. He stopped, and looked at it. The book began speaking to him, and told him what he was to do, and what to leave undone. It gave him a while series of orders and prohibitions. He found this curious, did not much like it, but he took it home to his [wife].
>
> "I found this book under a tree," he said to her, "which tells me to do all sorts of things, and forbids me doing others. I find this hard, and I will carry it back to where I found it," And this he did, too, although his squaw begged him to keep it. "No," he said, "it is too thick; how could I drag it about with me in my medicine-bag?" And he laid the book again the next day under the tree where he had taken it up, and so soon as he laid it down, it disappeared. The earth swallowed it up.
>
> Instead of it, however, another book appeared in the grass. That was easy and light, and only written on a couple of pieces of birch bark. It also spoke to him in the clear and pure Ojibbeway language, forbade him nothing and ordered him nothing, and only taught him the use and advantage of the plants in the forest and on the prairie.
>
> This pleased him much, and he put the book at once in his hunting-bag, and went into the forest and collected all the plants, roots, flowers, and herbs which it pointed out to him.
>
> Quite covered with herbs of fifty different sorts, he returned to his [wife]. He sorted them, and found they were all medicine, good in every accident of life. As he had in this way become a great medicine man, as well as a mighty hunter, he wanted but little more to satisfy his earthly wants.[222]

This story reveals the often-antagonistic relationship between Native peoples and missionaries, who sought to replace Native religious beliefs, customs, and practices, with Christian teachings. The book that gave "orders and prohibitions" was the Bible. Its rules were strict, foreign, and offered very little to improve the lot of the Ojibwe people. It was only when the first man discarded this book and returned to the teachings of the Ojibwe, recorded, as was customary, on birch bark, that he became content and gained the knowledge and power to be a "great medicine

[222] Johan Georg Kohl, *Kitchi-Gami: Wanderings Round Lake Superior* (London: Chapman and Hall, 1860), 200-201.

man." The Ojibwe saw Christianity, not medicine, as the real threat to their medical powers as it sought to disrupt their relationships to the spiritual world,

"Aboriginal Medical Art": Dr. Andros' (Mis)Interpretation of Ho-Chunk Medicine Ways

Dr. Andros, who served as physician for the Ho-Chunk Agency in the 1830s, 1840s, and 1850s, was just one of many physicians who interacted with the Ho-Chunk people over the course of the nineteenth century. He was born in Massachusetts around 1805 and earned degrees in medicine and literature from Brown University in the 1820s. His was not a typical pathway for men interested in obtaining licensure in the 1820s. In Europe, aspiring doctors sought training in clinics, but American medical students lacked that option. The new nation did not have large hospitals in urban centers where student doctors could gain practical experience. Instead, apprenticeship constituted the primary form of medical education. There was no standardized system for the completion of an apprenticeship and the education one received varied greatly depending on the personality and knowledge of the mentor. By the 1830s and 1840s, many more aspiring doctors began turning to formal schooling for their medical education, often at a proprietary (for-profit) medical school. These schools often competed for students by lowering the requirements for completing a degree. [223] However, with little interest at the federal or even state level to regulate medical education, the educational and experiential preparedness of medical doctors varied greatly throughout American society in the nineteenth century. Despite

[223] While apprenticeship still remained the primary pathway for medical training in the 1830s and 1840s, small, independent medical schools began popping up, particularly out West, loosely based on European models and largely replaced apprenticeship as the primary educational pathway for aspiring physicians. By 1840, medical coursework could include morbid anatomy, medical chemistry, and physiology to name a few. However, the majority of practitioners by 1830 had not taken a single course as part of their medical training. Thomas Neville Bonner. *Becoming a Physician: Medical Education in Britain, France, Germany and the United States, 1750-1945*. (New York: Oxford University Press, 1995), 33-60; 158-181.

the wide range of medical pathways to earning one's medical degree or status as a regular physician, practitioners adhered to a common system of medical belief when it came to health, healing, and the body – a system rooted in scientific inquiry.[224]

Dr. Andros' pathway to the North American West was fueled primarily by economic motivations. He belonged to a large movement of young Americans, particularly young men, who set their sights on the economic opportunities envisioned in the North American West. Transportation innovations facilitated travel while the growing demand for coal and iron led many young men to the mineral rich lands of North American West. The victory of Black Hawk's War and the subsequent opening up of indigenous lands for settlement helped initiate a new wave of white settlers to the region. Dr. Andros was part of this wave of emigration to the burgeoning lead mining settlements in the western Great Lakes in 1833. He settled in Dubuque along the Mississippi River, and opened a medical practice as one of three physicians in the growing town of roughly five hundred people. Dr. Andros' enjoyed a solid reputation within the town, standing in stark contrast to Dr. John B. Stoddard who practiced medicine without a medical degree. In contrast to Andros' medical degree, Stoddard used his experience as a hospital steward during the Black Hawk War as his period of apprenticeship and attempted to build a medical career after the war's conclusion. After Stoddard's treatment led to the death of a patient, he was forced to leave the settlement. Andros remained as one of only two physicians upon whom American miners and settlers could turn to for medical care and treatment.

In failing health by 1837, Dr. Andros removed to the rural north-eastern section of Iowa and took up farming. It is unclear what medical affliction he faced, but the move away from the

[224] See: Steven M. Stowe. *Doctoring the South: Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century*. Chapel Hill: University of North Carolina Press, 2004.

lead mining district did lead to the improvement of his health. Not long thereafter, he accepted an appointment as fort surgeon at Ft. Atkinson. He also became physician for the Winnebago Agency. His practice did not prevent him from participating as a member of the Territorial Legislature in 1843. In 1845, he did move with the Ho-Chunk to Long Prairie, but returned to Iowa in 1854 near the time the Ho-Chunk negotiated a new treaty in south central Minnesota. Dr. Andros continued to practice medicine in Iowa until 1882 when he moved to Mitchell, South Dakota and continued working as a physician.

Many physicians who worked among Native people were motivated by their religious beliefs. They saw medicine as another avenue for evangelical missionizing efforts. For example, Revered Thomas S. Williamson, who served as the head of the mission school at La Qui Parle among the Mendawakanton Sioux, was also their physician. Born in 1800 in South Carolina, Dr. Williamson studied medicine in Ohio and gained his medical license in 1823. After continuing his medical education at Yale University in 1824, Dr. Williamson practiced medicine in Ohio until he decided to attend Lane Seminary in 1833 to study Theology. in many ways mirrored the religious discourse associated with the Second Great Awakening, a period of religious transformation throughout the country.[225] Protestant revivalist preachers, including Charles Finney and Lyman Beecher, communicated an "activist" and "millennial" message. They argued that individuals, as moral free agents, could choose the path of holiness and, through their evangelical work, bring moral perfection to the world. This message was reform orientated: human beings were not only "accountable for their actions," but duty bound to

[225] This "period of religious ferment," according to scholar Claudia Stokes that began towards the end of the eighteenth century and reached a climax in the early 1830s, "usher[ed] in a religious climate characterized by populism and mounting democratic inclusiveness…[that] enabled figures on the religious periphery to move closer to the center." Cladia Stoke, *The Altar at Home: Sentimental Literature and Nineteenth-Century American Religion (*Philadelphia: University of Pennsylvania Press, 2014), 22.

influence and educate others on these responsibilities.[226] The Second Great Awakening significantly shaped the way in which individuals understood their own efforts at bringing about the millennium. One expression of this evangelical outreach centered on an effort to Christianize American Indians. It was through the American Board of Commissioners for Foreign Missions, an organization centered on this mission, that Dr. Williamson made his way west where he served as a missionary and agency physician among the Dakota Indians.

In 1883, Andros looked back on his interactions with Ho-Chunk healers during the first half of the nineteenth century and provided his own interpretation of their medicine ways in the *Journal of the American Medical Association*. He witnessed the human costs of repeated removals and relocations and the variations in the general health of the population depending on the conditions of the reservation.[227] His skill as a physician was put to the test in some surgical cases as well as during an outbreak of dysentery and smallpox for which the medical arsenal available at the time was extremely limited. But his work also brought him into contact with a system of healing very different from his own and one that at times sharply contrasted with his own perspectives and training. In commenting upon the significance of Andros' first publication on Ho-Chunk medicine practices, Dr. Edmund Andrews noted that his work contained "peculiar

[226] Ronald G. Walters argues that material conditions in the north in the first half of the nineteenth century, including technological innovations and the rise of industrialization, provided the necessary conditions for reform movements to emerge. He focuses on middle class reformers who sought "to impose moral direction" (9) throughout American society largely through inspiration from evangelical ideology during the Second Great Awakening. The emphasis on individual effort, largely through benevolent action, brought immediacy to reform movements such as abolitionism and temperance, among others. Ronald G. Walters. *American Reformers 1815-1860*. New York: Hill and Wang, 1978. See also: Hahn, *A Nation Without Borders*, 54-56; Haltutunen. "Humanitarianism and the Pornography of Pain," 303-334.

[227] *Historical Lectures upon Early Leaders in the Professions in the Territory of Iowa.* (Iowa City: State Historical Society, 1894), 5-6.

historical value" pertaining "to their original medical and surgical methods." Andrews argued that Andros' observations and intimate workings with the Ho-Chunk gave him a unique perspective on "aboriginal medical art."[228] Andros' work provides as a window onto the collision and mutual adaptation of Native and white American healing ideas and practices.

Andros' time among the Ho-Chunk both confirmed and challenged some of the preconceived ideas that men like him brought to their work. He divided Native medical practices into "two schools of medicine." The first relied upon "baths, bleeding and medicinal herbs" while the second "resort[ed] to the marvelous."[229] While the two were intimately woven together from an indigenous perspective, Andros sought to separate those aspects of Ho-Chunk medicine that he could admire from the spiritual aspects that he dismissed outright.

He described the first school of medicine as a system of healing that would not have differed drastically from the type of medicine used by a variety of practitioners within American society in the first half of the nineteenth century. It centered on removing illness from the body through a variety of means. For fevers, Andros explained, Ho-Chunk healers relied upon a "routine treatment" that combined the use of a purgative with water therapy. Treatment began with "an emetic or cathartic," a depletive treatment that would have initiated vomiting in the patient. This was followed with a shock of both hot and cold applications of water – a vapor bath immediately followed with the application of a cold bath, either by plunging the patient into cold water or a cold sponge bath. To give the patient a vapor bath, Andros detailed how Ho-Chunk healers constructed "a small tent, made by bending two small poles across each other and fixing the ends on the ground." The frame was then covered with skins and hot stones were

[228] Dr. F. Andros, "The Medicine and Surgery of the Winnebago and Dakota Indians," *Journal of the American Medical Association* (1883), 117.

[229] Dr. F. Andros. "Medical Lore of the American Indians" *Journal of the American Medical Association* 1, no. 13 (1883), 402.

placed inside and sprinkled with water to create steam. After this shock of both hot and cold water therapy, the patient was then "covered with blankets or skins" and given warm liquids to drink.[230]

Using a purgative, or emetic, as a first step in the treatment would have closely mirrored the type of medicine practiced by antebellum doctors such as Andros. Physicians of the period believed that restoring equilibrium to the body required their active intervention to restore the body's in-flows and out-flows. Prior to 1800 and dating back centuries to Hippocrates, physicians had focused their attention on allowing the body's natural healing powers to restore an individual back to health. However, by the early nineteenth century, practitioners had largely abandoned that outlook. Instead, according to historian James C. Whorton, "[p]ractitioners' true enthusiasm was for the heroic interventions that took the work of cure out of nature's hands and placed it in physicians'."[231] Benjamin Rush typified the type of medicine practiced by physicians of this period. The champion of "heroic medicine," Rush believed that "all local disease to be the result of vascular tension" and that the way to treat this underlying condition was through "depletive therapies."[232] These treatments were painful and often dangerous. However, they produced a visible response from the patient upon their administration, particularly in regard to the excretion and/or absorption of bodily fluids. By the 1880s, "heroic medicine" was increasingly coming under fire from younger doctors trained in Europe. These younger physicians had been exposed to advances in chemistry, physiology, pharmacy and clinical pathology. These new advances led many young physicians to doubt the efficacy of

[230]Andros, "Medicine and Surgery of the Winnebago and Dakota Indians," 117.

[231] Whorton, *Nature Cures*, 6.

[232] See: Starr, *Social Transformation of American Medicine;* Owen Whooley. *Knowledge in the Time of Cholera: The Struggle over American Medicine in the Nineteenth Century.* Chicago: University of Chicago Press, 2013.

heroic therapeutics, particularly bloodletting. These treatments did not conform to new ideas regarding the "anatomical basis of disease." This new turn towards the study of anatomy and the importance of autopsy in understanding how disease progressed in the human body cast doubt on heroic treatments. Despite these advances and critiques from younger physicians upon their return from France and Germany, older practitioners continued to rely upon heroic therapeutic remedies, particularly those who began practicing as physicians during the first half of the nineteenth century. It was not until the 1870s that more concerted efforts began to transform American medicine, but these changes did not produce steady progress towards scientific medical training until after 1890 and the bacteriological revolution.

In addition to bleeding as a common and sometimes first course of treatment, physicians drew upon a limited set of therapeutic remedies to treat disease and sickness. They relied upon opium for dysentery, quinine for fevers, opium and alcohol for pain, and calomel as a purgative. They used mercury for a variety of purposes, including malaria, and to treat all venereal diseases.[233] In fact, as competition from alternative practitioners increased, orthodox practitioners adhered more vehemently to their ways, "making depletive therapy the core of their self-image as medical orthodoxy."[234] This insistence upon active intervention continued to set physicians apart from other medical practitioners who largely defined their healing systems as siding with *vis medicatrix naturae,* "the healing power of nature."

The use of water as a therapeutic treatment by the Ho-Chunk would have also brought comparisons to hydropathy among readers of *The Journal of the American Medical Association*. Hydropathy was one of many alternative therapeutic systems that gained popularity in the first half of the nineteenth century. Growing doubt and skepticism within the American public,

[233] Gillet, *The Army Medical Department, 1818-1865*, 3-16.
[234] Whorton, *Nature Cures*, 7.

particularly in response to the ineffectiveness of heroic therapies, led to a rise in alternative therapeutics in the early decades of the nineteenth century. Adherents to hydropathy believed that internal and external applications of water could be used to expel impurities within the body both to restore the body to health and to prevent illness.[235] As with all "irregular" therapies of the period, physicians dismissed these systems as unscientific and the people who practiced these types of medicine as "quacks." By associating the practical aspects of Ho-Chunk medicine to hydropathy, which was failing out of favor by the time he published his editorial, Andros sought to clearly distinguish Ho-Chunk medicine from the type of medicine practiced by men like himself.

In addition to the use of purgatives and water therapy, Andros detailed how Ho-Chunk healers relied upon bleeding to treat a wide range of medical problems. He noted that Ho-Chunk healers "use[d] a thin scale of flint, fastened by a screw in a stick and driven into the vein." Bleeding, in particular, was a mainstay of western medical practice during the time Andros practiced among the Ho-Chunk and, in fact, was often the first course of treatment.[236] However, Andros was critical of the rude application of bleeding, or bloodletting, as a therapeutic treatment as well as the way it was used "without regards to sex, age, or physical condition."

Andros recognized the ability of Ho-Chunk medicine men to meet the needs of many patients and he sought to translate their skills into language that seemed to verify their general understandings of how the physical body functioned. While Ho-Chunk medicine men were not classically trained in understanding the physiological and anatomical properties of the human

[235] For discussions on hydropathy, see: Whorton. *Nature Cures.*

[236] According to historian John S. Haller, "doctors preferred to bleed prior to all other remedial measure, especially emetics, cathartics, sudorifics, and blisters." John S. Haller, Jr. *American Medicine in Transition, 1840-1910* (Urbana: University of Illinois Press, 1981), 36.

body, Andros admitted that they understood many important aspects of how the body functioned as well as the role of many of vital organs. He recalled,

> They have no idea of the functions of the lungs in the oxygenation of the blood, or of the kidneys in conveying off the nitrogenous elements from the system, and yet they know from observation that the suspension of the functions of either will be fatal to lie…They have no definite idea of circulation of the blood, and yet they know that the heart is the organ which propels the blood through the body.[237]

From Andros' perspective, the Ho-Chunk's general understanding of the body helped them in their ability to meet the needs of their patients.

Andros, who witnessed Ho-Chunk healers treating trauma wounds, found them to be very capable. For one particularly difficult case of a compound fracture of the leg, with breaks in both the fibula and tibia as well as lacerations to the skin, he observed the successful treatment by the medicine men and the full recovery of the patient. In detailing this particularly challenging case, Andros wrote:

> I once saw a case of compound fracture in the leg, four or five inches above the ankle. Both tibia and fibula were broken, and the soft parts much lacerated. A semi-cylindrical piece of bark was procured, considerably larger than the limb. This cylinder was filled with soft clay and the limb embedded in it, from the heel to the groin, except the wounded portion, which was left open. The wound was kept clean and dressed with the thick mucilage of elm bark. The patient made a rapid recovery, with but little shortening.[238]

The medicine men effectively created a cast to immobilize the fractured limb while it healed. Further, keeping the "wounded portion" open and cleaning it with "elm bark" proved effective at staving off infection.[239]

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[237] Dr. F. Andros. "Medicine and Surgery of Winnebago and Dakota Indians," 117.

[238] Ibid.

[239] Other Native peoples, including the Cree Indians, similarly used herbal remedies as antiseptics. Volney Steele. *Bleed, Blister, and Purge: A History on the American Frontier* (Missoula: Mountain Press Publishing Company, 2005), 28-29.

Clearly Andros respected the ability of the Ho-Chunk medicine men to successfully save the life of the patient, as well as the limb, and he credited their exceptional skill and healing abilities in dealing with fractured bones. In such a case, Andros would have likewise immobilized and bound the leg.[240] However, the fact that the patient suffered a compound fracture so close to his ankle would have complicated Andros' decision making in regards to his method of treatment. The medical community at this time recognized this injury as "particularly dangerous." A successful outcome would not have been easily attainable even by the most skilled physician. John Bell, a physician in England, wrote in the *Principles of Surgery* in 1826 that

> When…the ancle [sic] joint is burst up, the astragalus broken to pieces, or turned out through the wound, the lower end of the tibia shattered and protruded, and the fibula also broken, the disorder is such as to defy the powers of nature, and art can do but little. This is of all the cases the most perplexing to the judgment, and distressing to the feelings of the surgeon, who often wavers in fear and anxiety, for some days desirous of saving the limb, and yet fearful of losing the patient's life, till at last the fatal gangrene appears, and he feels most poignantly the fault he has committed a fault who has attempted to save a man's limb, though at the risk of his life. Yet the surgeon, though he have acted deliberately, conscientiously, sensibly, and humanely; though he has been supported by the countenance of his fellow surgeons; still, when misfortune comes, must feel himself unhappy.[241]

Though Bell acknowledged that it might be tempting to try and save the limb, "as an express unconditional rule of practice," a trained physician should amputate the leg.[242] Thus, if the patient had been placed in the care of Andros, it is very possible that he would have made the

[240] John Bell. *The Principles of Surgery, as they relate to wounds, ulcers, fistulae, aneurisms, wounded arteries, fractures of the limbs, tumors, the operations of trepan and lithotomy. Also of the duties of the Military and Hospital Surgeon*. Vol II. (London: T. Tegg, 1826), 185. American physicians looked to Europe, particularly England, as a source of medical knowledge and as a model for the profession to emulate as a whole. Starr, *The Social Transformation of American Medici*ne, 37-40.

[241] Starr, *The Social Transformation of American Medicine*, 37.

[242] Ibid, 38.

decision to amputate the patient's leg. In fact, Andros noted his frustration that Ho-Chunk medicine men refused to amputate at all.

The successful use of the "elm bark" to stave off infection was just one way that Andros observed the ability of Ho-Chunk medicine men to draw upon herbal remedies to effectively treat ailments. From asthma to fevers, poisonous bites, dysentery, and diarrhea, Ho-Chunk healers had a large pharmacopeia at their disposal. For rattlesnake bites, Andros noted the application of "the bruised leaves of the common plantain, or black snake root" to be a successful treatment. For bee and wasp stings, his personal experience confirmed the beneficial properties associated with the application of wild onion to relieve pain "instantly."[243] He observed the successful use of the bark of buttonwood trees to treat dysentery and conceded that "they were more successful in the treatment than I was." He even admitted to incorporating the knowledge he obtained into caring for patients later at his own private practice.[244] Andros was not alone in making this observation. A physician who worked among the Cree Indians noted: "Although the list of materia medica is a small one there is remarkable judgment shown in the choice of remedies…[T]he bark of the juniper and Canada balsam tree are doubtless as good an application to wounds as a people unversed in antiseptic application and ignorant of the existence of bacteria could devise."[245] Both doctors observed the knowledge and skill exercised by Native healers in the application of herbal remedies.

In addition to the use of bleeding, herbal remedies and the adept skill of Ho-Chunk healers in setting fractures, Andros noted their skill at treating wounds, including those from

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[243] Ibid, 38.

[244] Andros, "The Medicine and Surgery of the Winnebago and Dakota Indians, "118.

[245] Holmes, E.M. (F.L S.), "Medicinal plants used by the Cree Indians, Hudson's Bay Territory." *The Pharmaceutical Journal and Transactions*, 3d ser. Vol.15, (London: 1884), 304-305 as quoted in Frances Densmore. *How Indians Use Wild Plants for Food, Medicine & Crafts* (formerly titled *Uses of Plants by the Chippewa Indians*). (New York: Dover Publications, Inc., 1974), 322.

gunshots. Despite his frustration that Ho-Chunk healers refused to amputate, Andros detailed the care taken when treating a "large incised wound." For this type of injury, "the parts [were] carefully brought together and secured with sutures of animal sinew" that had been "smoke dried" to prevent absorption by the body. Ho-Chunk healers believed that it was necessary for the wound to heal first from the inside and they aided this process by "putting a think piece of bark between the edges of the wounds." Healers used a similar process in treating gunshot wounds. After cleaning the wound with "a poultice of slippery elm bark or the young sprouts of the basswood," the wound was "kept moist with a mucilage from the bark."[246] When infection set in and patients died, Andros blamed the "ignorance" of patients in not following the careful instructions of the healer. When patients died in his care, Andros similarly cast blame on the inability of patients to follow his instructions.

In many ways Andros challenged popular perceptions about indigenous healing practices. Many physicians believed that Native systems were inadequate in addressing medical need within Native populations. Benjamin Rush was very vocal in his dismissal of Native healing practices, especially when compared to western medicine. In an address to members of the American Philosophical Society on the differences between Native health and healing traditions from Europeans, he asserted, "It would be a reproach to our schools of physic, if modern physicians were not more successful than the Indians, even in the treatment of their own diseases."[247] He credited Native peoples for their skills "relat[ing] to hunting and war." In these areas, he acknowledged, "the Indians have acquired a degree of perfection that has not been

[246] Andros, "The Medicine and Surgery of the Winnebago and Dakota Indians," 117.

[247] Benjamin Rush. *An oration, delivered before the American Philisophical Society, held in Philadelphia on the 27th of February, 1786; containing an enquiry into the influence of physical causes upon the moral faculty*. (Ann Arbor, MI: Text Creation Partnership, 2008-2009), http://name.umdl.umich.edu/N15651.0001.001, 60.

equalled [sic] by civilized nations." But her urged his audience to "remember that medicine among them does not enjoy the like advantage."[248]

Rush, like many others who dismissed Native healing traditions, based his assertions on Native peoples' responses to smallpox. He insisted that there was not "a stronger mark of the imperfect state of knowledge in medicine among the Indians, than their method of treating" smallpox. Rush did not base these ideas on his own observations, but rather relied on outside sources that pointed to the act of "plung[ing] themselves in cold water, in the beginning of the disorder" was especially ineffective and often led to the patient's death.[249] David H. Davis, sent in 1832 to vaccinate the tribes of the Upper Missouri, obtained information regarding their state of health. He interviewed a man who had lived in the area for eighteen years. The man noted their "ignorance" of the Indians and their "limited means of treatments" for smallpox. Davis himself was particularly shocked at the Native response to gonorrhea and syphilis which he noted "they leave entirely to nature to effect a cure."[250] By the 1830s, physicians were using mercury to treat those diseases.

In some, but not all cases, Andros revealed that once "the medicine man has exhausted his store of knowledge," the Ho-Chunk turned to ceremony and ritual to heal the patient. Before the ceremony could begin, Andros observed the careful construction and preparation of the lodge, where the ceremony would take place, by nearly all within the village. To him, the preparation and construction of the lodge was itself a spectacle that took place with "great pomp and parade." Such care was taken in the construction of the lodge that, according to Andros, no two pieces of wood were alike. After they finished erecting the lodge and placed the patient

[248] Rush, *An Oration*, 37.
[249] Rush, *An Oration,* 33.
[250] David H. Davis to the Secretary of War. Oct 21, 1832. NARA RG 75 Letters Received from the Office of Indian Affairs,

within it, the "Great Wabeno" made his entrance.[251] Andros described the "Great Wabeno" as an individual "fantastically dressed with drum and rattle" and tasked with "the burden" to "request to the spirit of disease to vacate the premises." He performed the healing ceremony through a combination of "improvised song" and a performance that included laying his hands on the patient and "sucking the flesh of the patient in different parts." Even the audience within the lodge participated in the performance. When it was decided "that the disease was incurable," the audience would begin "firing guns, beating drums and howling" in order to scare away the Bad Spirit "who [hovered] around to seize the soul ready to depart."[252]

According to Hoffman, Wabeno was a term used among several Indian groups to denote a specific class of healers, or shamans. Although Hoffman admitted that Wabeno were "not thoroughly understood, and their number…so extremely limited that but little information respecting them can be obtained," he was able to ascertain that Wabeno received their calling through a vision or dream. What set them apart from other classes of shamans was that "evil manidos," or spirits, were believed "to favor" them. This provided them with the power to exercise "malevolent manidos, especially such as cause disease." They were not members of the Midewiwin and were considered a corrupt version of the Mide. Further, they were believed to be "of modern origin" and perhaps tied to the introduction of Christianity.

Andros claimed authority to what he termed the Ho-Chunk's "sacred lodge," although from Hoffman's description of the Wabeno, it is unlikely that Andros was introduced or admitted into the Medicine Dance. It cannot be discounted, however, that Andros was perhaps allowed to witness some aspects of the Medicine Dance ceremonies or rituals. W. W. Warren, in his

[251] Hoffman, *The Mide'wiwin,* 8-11.
[252] Andros, "Medical Lore of the American Indians," 402.

history of the Ojibwe, admitted that sometimes outsiders were allowed to "[enter] into the lodge itself, while the ceremonies [were] being enacted." This did "not initiate a person into the mysteries of the creed, nor [did] it make him a member of [their secret religious society]."[253] However, it did allow outsiders some degree of access into the intimate workings of the tribe.

Whatever his degree of access, Andros regarded the ceremony and ritual associated with what he called "the second school of medicine" as nothing more than trickery or magic. His was a common response to nearly all competitors to the medical profession throughout the nineteenth century. He noted, "The effect produced is the same I have seen in animal magnetism among the whites. The singing is really ventriloquism, the sound seeming to come from above and not from the lips of the performer." His reference to animal magnetism, one of many alternative healing systems that emerged in the 1800s, would have provided a point of comparison that most of the readers of the *Journal of the American Medical Association* would have understood. Critics largely dismissed animal magnetism as "a delusion," "untrue", and even worse, "an imposition."[254] Through this comparison, Andros sought to diminish the power demonstrated by the "Great Wabeno" during the ceremony as nothing more than a performance built upon misperception and illusion.

Andros believed that the entire ceremony was built upon deceit as it allowed the medicine man to take credit for the recovery of the patient without bearing responsibility for the deaths. He argued,

> If the medicine man is successful and the patient recovers it adds to the reputation of the magician, and as among the doctors of the present age, he wrests from the *vis medicatrix*

[253] W.W. Warren. "History of the Ojibway Nation." Ed. Dr. E.D. Neill. Collections of the Minnesota Historical Society vol. 5 (1885), 65-66. Cited in Hoffman, *The Mide'wiwin*, 13.

[254] C. Poyen, *Progress of animal magnetism in New England: Being a collection of experiments, reports and certificates, from the most respectable sources. Preceded by a dissertation on the proofs of animal magnetism.* (Boston: Weeks, Jordan & co., 1837), 17.

> *naturae* the credit of the cure. If the patient dies its all right, they are satisfied that the disease was incurable.[255]

Andros was unwilling to grant credit to the medicine man for the recovery of the patient. He referenced *vis medicatrix naturae*, Latin for "the healing power of nature" to undermine the power associated with the healing ceremony. Rather, Dr. Andros granted credit to the power of the body to "restore itself to health."[256] Further, with a way to incorporate both positive as well as negative results, there was no method of accountability in the efficacy of the ceremonies. To Andros, the ceremonies associated with the Medicine Dance of the Ho-Chunk people was a deceptive act by the "Grate Wabeno" that fooled the people into believing in the ceremony. If a patient did recover, he made sure to note that it happened despite the ceremony and should be credited to the restorative powers of the body.

Andros' critiques of the spiritual aspects of Ho-Chunk medicine ways followed a familiar response by physicians to nearly all alternative therapeutic systems that emerged throughout the nineteenth century. Despite growing challenges to the status of physicians during this period, these men adhered to the belief that they were the most suited and best prepared to heal ailments of the body. Despite the revocation of state licensing laws beginning in the 1830s, a rise in competition from therapeutic practitioners, and increasing competition within the profession as a result of the rise and proliferation of for-profit medical schools in the 1840s and 1850s, these men continued to paint outsiders as "quaks." Historian Regina Morantz-Sanchez argues, that this "degeneration of medical education in the first half of the nineteenth century made a

[255] Andros, "Medical Lore of the American Indians," 402.

[256] "*Vis medicatrix naturae* – the healing power of nature – was the Latin phrase that had been used for centuries to signify the agency first identified by Hippocrates, the inborn ability of the human body to respond to the insult of illness or injury and restore itself to health in most episodes of disease or trauma." Whorton, *Nature Cures*, 6.

mockery of physicians' claims to superior skill."[257] The American public remained extremely skeptical of the abilities of doctors and contributed to the lowly status and increasing criticism of physicians in comparison to other sectarian practitioners at this time.[258]

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For the most part, disparate views on health, healing and the human body did not impact interactions between physicians and Native peoples during the first half of the nineteenth century. Physicians, including Andros, recognized medicine men as being extremely capable of meeting a wide range of medical need. They testified that Native groups used physicians' services selectively as an accompaniment, not a replacement, of traditional practices. Further, the status of medicine and the type of therapeutic remedies that physicians drew upon did not contrast significantly with the more practical elements of Native healing traditions. Some Indian agents floated the idea that physicians could serve as "civilizing" agents and some physicians sought to diminish the role of medicine men within the tribe, but neither of those agendas came to fruition during this early period of interaction.

There were, however, strains in the relationship between the physician and the Ho-Chunk people and government physicians was not always harmonious. Native medical views challenged physicians who looked to science, not the spiritual world, to treat ailments of the body. In 1850 during a particularly difficult winter, Agent J. E. Fletcher noted that while some sought care from the physicians, others "still employ the medicine men of the tribe." From

[257] Regina Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine*. Chapel Hill: The University of North Carolina Press, 1985), 30.

[258] Morantz-Sanchez, *Sympathy and Science*, 28. See also: Ludmerer, *Learning to Heal*, 9-20; John Harley Warner, *Against the Spirit of the System: The French Impulse in Nineteenth-Century American Medicine* (Baltimore: Johns Hopkins University Press, 2003), 18.

Fletcher's perspective, these medicine men used their position within the tribes to exact "high fees" and worked to "shift the responsibility" of death to physicians by requesting their care only after it's ascertained that the "patient will likely die."[259] Dr. Thomas S. Williamson who practiced among the Medawakantonwan Sioux saw this type of behavior as purposefully designed to undermine the credibility of western medicine. He sought to break the ties between the people and the medicine men by visiting the sick and providing medicine only if the patient had not sought prior care from a traditional healer. However, there was not much that the agent could do to mitigate the influence of traditional healers within the community at this time. When it came to treating illness within their community, the Ho-Chunk navigated both medical worlds on their own terms.

In many ways Dr. Williamson's actions foreshadow the efforts of physicians beginning in the late nineteenth to sever ties between Native peoples and medicine men under the belief that "civilization and education of federal wards entailed a homogenization of belief and practice."[260] Advances in medicine coupled with the emergence of a more aggressive and powerful federal government after the Civil War, profoundly affected interactions between physicians and Native peoples. For medicine men and women of the Great Lakes, and the Native communities within which they practiced, these policies would have profound consequences.

[259] J. E. Fletcher. Annual Report (1850), ARCIA, 69.

[260] Thomas H. Lewis, *The Medicine Men: Oglala Sioux Ceremony and Healing (* Lincoln: University of Nebraska Press, 1990), 3.

Chapter Four

The System Expands: Disease, Government Physicians, and Native Labor in the Pacific Northwest

Over the 1840s and 1850s, the nation's nascent federal Indian health care system expanded westward across the Central Plains and the Pacific Northwest. The Saganaw band of Chippewa Indians, the Sauk and Fox, Mdewaknaton Sioux, Nisqually, Puyallup, Umpqua, Nez Perce, and Walla Walla are just a few of the dozens of groups who received the services of a government physician and integrated western medical care into their communities, to varying degrees. Native people acquired these services in exchange for land cessions and, towards the 1850s, for their confinement to reservations. At not time or place did this system expand more rapidly than in the Pacific Northwest from 1854 to 1855. During this two-year period, federal commissioners Isaac Stevens, the territorial governor of the Washington Territory, and Joel Palmer, Superintendent of Indian Affairs for Oregon Territory, negotiated eighteen treaties that transferred title to most of the region from Native groups to the United States (see table 1).[261] These treaties not only helped extend American hegemony into the region, but also greatly expanded the scale and scope of the federal Indian health care system. Nearly all treaties contained provisions for medical care, the purchase of medicines, and in some cases, the construction of a hospital at the reservation agency. These treaties of the mid-1850s established medical care as an all but standardized part of treaty agreements from that point forward.

Provisions for medical care in the Pacific Northwest served federal interests in two ways: they facilitated Native dispossession and supported the creation of a healthy Native labor force.

[261] Joel Palmer negotiated eight treaties, Stevens negotiated seven treaties, and together they negotiated three treaties.

Palmer and Stevens borrowed from earlier treaties, including the 1832 treaty with the Winnebago and the 1854 treaty with the Missouri and Otto, both of which exchanged medical care for land cessions. Palmer and Stevens applied these models to treaty negotiations with great success, particularly among the coastal groups with whom the federal commissioners first negotiated. Offers to provide the services of a government physician and funds for the purchase of medicines appear to have made some more willing to accept the terms offered by the commissioners. As one commissioner noted in his report to Washington on the progress of treaty negotiations, provisions for medical care seemed to help "overcome their objections" during the negotiation process.

While Native people along the Pacific Coast had their own traditional healers and medical practices, they were not opposed to integrating new medical knowledge into their communities. In fact, medical interactions between Native groups and the Hudson Bay Company were occurring prior as early as the 1830s. As infectious disease outbreaks, including "intermittent fever" (malaria) and smallpox, struck communities with increasing frequency beginning in the 1830s, Native groups became more invested in securing medical assistance.[262] Stevens and Palmer capitalized on this adaptive strategy to secure the transfer of most indigenous lands to the federal government and the confinement of these groups to reservations.

The Federal Government's inclusion of medical care in nearly all treaties with Native groups of the Pacific Northwest also facilitated the labor system that was emerging in the region during the 1850s. White citizens wanted Native lands, but they also heavily relied upon Native labor. While California experienced rapid population growth in the 1850s, the white population

[262] See: Robert T. Boyd. *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*. Seattle: University of Washington Press, 1999.

in relation to the region's indigenous population was still rather small and many white communities were isolated from each other. In Puget Sound in the early 1850s, it has been estimated that Native peoples outnumbered white settlers ten to one, with some estimates as high as fifteen to one.[263] These population disparities, coupled with their identification as free territories, meant that white settlers who wanted access to outside sources of labor had to look to Native peoples to supply their needs. They turned to Native laborers for assistance with food production, construction, transportation, navigation, and farming. Stevens and Palmer were well aware of the unique labor relations that characterized the region at this time. Stevens, in particular, envisioned federal Indian policy as a way to meet the needs of white settlers and industrial interests. In fact, he proposed nearby reservations as a way to provide white settlers with access to lands while maintaining access to a nearby labor source. Treaty provisions that included medical services, then, cannot simply be viewed as providing federal officials with leverage to secure land cessions. We must view them in the context of prevailing labor relations. Settlers wanted their workers to be healthy.

[263] SuAnn M. Reddick and Cary C. Collins, "Medicine Creek to Fox Island: Cadastral Scams and Contested Domains," *Oregon Historical Quarterly* 106, no 3 (Fall 2005), 377

Table 4.1: Treaties Negotiated between 1832 and 1855 that Included Provisions for the Purchase of Medicines, the Services of Physicians, and/or the Construction of Hospitals in Exchange for Land Cessions

Tribe(s)	Year Treaty Negotiated	Commissioner(s) who Negotiated Treaty	Provisions
Winnebago (Ho-Chunk)	1832	John Reynolds Winfield Scott	Services of a Physician
Mdewakanton Sioux	1837	Joel R. Poinsett	Medicines and Support of a Physician
Saganaw band of Chippwea Indians	1837	Henry R. Schoolcraft	Services of a Physician
Sauk and Fox	1842	John Chambers	Funds for Medical Purposes
Otto and Missouri	1854	George W. Manypenny	Funds for medical purposes (at discretion of president)
Omaha	1854	Geroge W. Manypenny	Funds for medical purposes (at discretion for president)
Umpqua and Kalapuya	1854	Joel Palmer	Funds for Medical Purposes
Nisqually, Puyallup, Steilacoom, Squawskin, S'Homanish, Stehchass, T'Peeksin, Squi-aitl, Sa-heh-wamish (tribes of Puget Sound)	1854	Isaac I. Stevens	Services of a physician, medicines, and smallpox vaccines
Kalapuya and confederated bands of Willamette Valley	1855	Joel Palmer	Services of a physician
Dwamish, Suquamish, and S'Klallam	1855	Isaac I. Stevens	Services of a physician
Makah	1855	Isaac I. Stevens	Services of a physician
Walla-Walla, Cayuse, and Umatilla	1855	Joel Palmer Isaac I. Stevens	Services of a physicians and medicines
Yakima	1855	Isaac I. Stevens	Construction of a Hospital, Services of a Physician
Nez Perces	1855	Isaac I. Stevens	Construction of a Hospital, Services of a Physician
Tribes of Middle Oregon	1855	Isaac I. Stevens Joel Palmer	Services of a Physician, Medicines
Quinaielt and Quillehute	1855	Isaac I. Stevens	Services of a Physician
Confederated Tribes of Flathead, Kootenay, and Upper Pend d'Oirelles	1855	Isaac I. Stevens	Services of a Physician

Source: Kappler, *Indian Treaties*, Vol II

American Interests in the Pacific Northwest: Securing Access to Native Lands and Native Labor

United States' interest in the Pacific Northwest, defined as the region bounded by the Pacific coast to the west and the Rocky Mountains to the east (present-day Oregon, Washington, Idaho, as well as portions of Colorado and Montana), began in the late eighteenth century shortly following Independence. As early as the 1780s, merchants discovered economic opportunity in the sea otter trade.[264] Their interest in the fur drew them to the peoples, inlets, and harbors of the coast. Meanwhile, Thomas Jefferson's purchase of the Louisiana Territory in 1803 and the Lewis and Clark's expedition that began in 1804 fueled visions of a contiguous nation extending from the Atlantic to the Pacific Ocean. One impediment to actualizing this imperial vision was Great Britain's foothold in Oregon. The two sides settled on joint occupation of the region in 1818 which tempered tensions for a time, but failed to create a lasting resolution.

White settler migration to the region beginning in the late 1830s and accelerating in the 1840s made joint occupation of the region untenable for United States' interests. The overland migration of citizens to the Oregon Territory began in very small numbers in the late 1830s, during a period of economic downturn, and accelerated beginning in the 1840s. Push factors (economic conditions in the east) encouraged emigration westward, but pull factors also lured settlers to the region. News of the rich, fertile lands of the Willamette Valley, south of the Columbia River, attracted many settlers in the 1840s. The harbors drew railroad speculators and surveyors to the region. They looked forward to a time when Puget Sound would become a commercial hub.[265] The region's large Native population also drew Protestant missionaries who

[264] Coll Thrush, *Native Seattle: Histories from the Crossing-Over Place* (Seattle: University of Washington Press, 2007), 20-27

[265] White, *It's Your Misfortune*, 72.

saw an opportunity to extend their efforts at the Christianization and "civilization" of North American peoples. Following the Missouri Crisis of 1819-21, Northern Whigs and Democrats began looking to the Pacific Northwest as a potential counterweight to the political influence of the slave south – a means of maintaining the balance between free and slave states. Extending American sovereignty in the region and delineating a border between the United States and Great Britain assumed new urgency. Thus, it was the combination of economic, religious, and political factors that propelled federal officials to negotiate a new deal with Great Britain.[266]

The United States reached a diplomatic truce with Great Britain in 1846 that secured the annexation of lands below the 49th parallel to the United States and allowed the Federal Government to respond to an increasingly demanding white settler population. Officials organized the Oregon Territory in 1848 followed by the Washington Territory in 1853. Congress sought to incentivize white settlement to the region through land policies including the *Oregon Land Donation Act* of 1850.[267] This act granted white citizens generous homesteads (320 acres for white male citizens and an additional 320 acres for their wives) as part of an effort to expedite the territory's admission as a state.[268] Arthur Denny, who undertook the overland journey from Illinois to Puget Sound admitted that the *Land Act* was the primary motivating factor that lured settlers like him to the region. He wrote in his memoir: "The object of all who came to Oregon in early times was to avail themselves of the privilege of a donation claim."[269] These settlers staked claims to lands, negotiated amongst themselves to ensure access to

[266] By 1845, Americans outnumbered British traders of the Hudson Bay Company in the region, roughly 5,000 to 750 persons. White, *It's Your Misfortune*, 72.

[267] Ibid, 76-77.

[268] In 1848, the Oregon Territory encompassed the future states of Oregon, Washington, Idaho, and portions of Montana and Colorado. Settlers in the northern region of the territory successfully pushed for Congress to create a separate territory, the Washington Territory, in March of 1853.

[269] Arthur Denny, *Pioneer Days on Puget Sound* (Seattle: C. B. Bagley, 1888), 16

desirable locations, sold their claims or portions of their claims to other settlers, and filed their claims at the land office in Oregon City on the assumption that the land was for the taking.[270]

The *Land Act* gave distributed land that had not yet been secured from the region's indigenous peoples in part because the first attempts to negotiate treaties with Native peoples and secure land cessions largely failed. In 1850, John P. Gaines, Alonzo A. Skinner, and Beverly S. Allen negotiated nineteen treaties during their assignments as federal Indian commissioners. Their orders were to reach an agreement that would result in the removal of all tribes west of the Cascades to the east of the Cascades, thereby opening coastal lands for white settlement. Gaines, Skinner, and Allen were unable to secure the removal of the western groups. Rather, the treaties reached between the two sides would have allowed these groups to stay in the Willamette Valley. The commissioners noted labor relations between Native laborers and white settlers as the reason for such concessions. White settlers, unable to fulfill their labor needs due to a "scarcity of white workers," turned to Native people for their labor needs. All nineteen treaties were summarily rejected by the Senate.[271]

The year 1853 saw renewed attempts to achieve Native removal. Indian Commissioner George Manypenny tasked Joel Palmer, whom he appointed the Superintendent of Indian Affairs for the Oregon Territory and Isaac Stevens, who assumed the responsibilities of the Superintendent of Indian Affairs in accompaniment with his duties as the territorial governor of Washington Territory, to succeed where others before them had failed. Palmer came with prior experience in the region, having joined in overland migrations in the 1840s. Stevens, however, held a more powerful position in his dual role as territorial governor. He exerted a powerful and

[270] Ibid, 19-24.
[271] Reddick and Collins, "Medicine Creek to Fox Island," 376-377.

heretofore unacknowledged influence over federal Indian policy in the region and his views on conducting treaty negotiations were forged from his earlier years and experiences. Born in 1818, Stevens grew up in the Northeast and attended to the Military Academy in West Point where he graduated the valedictorian of his class.[272] After graduation, he served in the Army Corps of Engineers where he oversaw the construction of federal projects including roads, canals, and even fortifications. When the war with Mexico began, Stevens requested a transfer to the Rio Grande in 1847 and joined the campaign under General Winfield Scott. He returned to the Army Corps of Engineers after the war, and became more active politically. He was promoted to the position of assistant director of the US Coastal Survey in 1849, tasked with mapping the America's newly extended Pacific coastline following the acquisition of Alta California following the US-Mexico War. After supporting Franklin Pierce's nomination for the presidency, Stevens lobbied for the position of territorial governor of the newly created Washington Territory in 1853. Pierce granted the request when he became President.[273]

Stevens' first assignment as Superintendent of Indian Affairs was to gather information about the region's indigenous peoples prior to opening treaty negotiations. Commissioner Manypenny wrote to Stevens that the current information relating to Native groups in the Washington Territory was currently of an "unsatisfactory and vague character." The first part of this job, Manypenny explained, was to gather knowledge about the region that "may prove useful." Specifically, he instructed Stevens to record the number and location of Native groups, their "general character and disposition, whether warlike and unfriendly or the reverse," and their relationship with the "white inhabitants and the Hudson Bay Company." He also requested

[272] Richard Kluger, *The Bitter Waters of Medicine Creek: A Tragic Clash Between White and Native America* (New York: Vintage, 2012), 3-6.
[273] Ibid, 3-16.

information on current relationships "which should be respected and conformed to by the government" as well as cost estimates for establishing and supporting agencies in the region. As Manypenny instructed Stevens, these costs should be "be guided by considerations of sound policy and efficiency."[274]

Stevens accumulated knowledge about the regions' Native peoples during a survey and exploration trip for a northern route for the Pacific Railroad Company. Neither Stevens nor Manypenny saw this dual assignment as involving any conflict of interest. In fact, Manypenny welcomed the association with the Pacific Railroad Company because funds were not yet available to support the information gathering mission. (Although Palmer had accepted appointment from Manypenny, he refused to follow through due to lack of funds.)[275] Clearly, Stevens' dual role as agent and railroad surveyor was mutually beneficial to the railroad and Indian Office. Stevens began his survey in the Upper Missouri and worked his way westward to Olympia in the Washington Territory. As he mapped potential railroad routes, he informed Manypenny and the Office of Indian Affairs of the knowledge gained about the region's Native groups, their numbers, their needs, their wants, and cost estimates to hold treaty councils.[276] While Stevens wrote to Manypenny that he would assume the tasks of his position with the utmost attention to serving "public interests,"[277] already, it appeared, Stevens impact on shaping US Indian policy in the region would be in concert with the interests of the railroads. Indeed the interests of the federal government and the railroad were entirely aligned.

[274] George Manypenny to Isaac Stevens. May 9, 1853. Annual Report (1853), ARCIA, 213

[275] Joel Palmer to George Manypenny, Commissioner of Indian Affairs. May 28, 1853. RG 75 Records of the Oregon Superintendency M2, Roll 3 Regional Archives Riverside.

[276] Isaac Stevens to George Manypenny. September 9, 21, 1853. Annual Report (1853), ARCIA, 220-222

[277] Isaac Stevens to George Manypenny. January of 1854. [Olympia, Puget Sound] Records of the Oregon Superintendency, M2, Roll 4 Regional National Archives, Riverside.

During his survey expedition, Stevens learned that labor relations between Native groups and Euro-American traders and merchants varied widely. Both Palmer and Stevens discovered ties between along the Pacific Coast. Near the Port Orford district, Palmer noted a diverse population of Native groups whom he identified as comprising several different bands, living in an area that included the coast from the California boundary line to north of Coquille, Oregon and extending inland to the mountains. He remarked that "excepting the Chetcas and Coquilles, I found these Indians at peace with the whites and among themselves." He also discovered that unique labor relations existed between the two. He wrote, "Since the coming of the whites many of the men have entered their employ, and prove faithful and industrious."[278] Stevens similarly remarked upon labor relations between white settler and Native laborers near Puget Sound. He witnessed Native people performing a variety of labors: Native men transporting whites along the inlets and harbors of Puget Sound, Native women assisting in domestic chores, including laundry, and Native men planting and sowing fields.[279]

Labor relations between white Americans and Native coastal groups were built upon ties established in prior decades. In Puget Sound specifically, the Nisqually, Umpqua, and Puyallup people had developed strong economic ties with the Hudson Bay Company (HBC), the British fur trading company that began operating in the region in 1821. HBC utilized the labor of the region's coastal populations for trading activities. Native peoples hunted deer, fished salmon, and collected animal skins and traded them for variety of European manufactures, including beads, knives, and mirrors, as well as tobacco. HBC employees also relied upon Native peoples as guides, interpreters, and informants. And when HBC diversified its economic activities to

[278] Joel Palmer to George Manypenny. September 11, 1854. Annual Report (1854), ARCIA, 259.
[279] Reddick and Collins, "Medicine Creek to Fox Island," 378.

include agricultural production, the company employed Native peoples to tend crops and livestock.[280] In sum, the labor of Native peoples was vitally important to the economic success and sustainability of HBC activities in the Pacific Northwest in the early nineteenth century.

Their reliance on Native labor prompted HBC employees to establish "orderly, mutually agreeable relations" with the region's diverse Native populations and their efforts to achieved that goal included the offer of medical care.[281] As was the case in many other parts of North America, Euro-American activities in the Pacific Northwest brought the spread and devastation of epidemic diseases. William Fraser Tolmie, a trained physician and director of HBC beginning in 1833, provided medical care in the course of his interactions with the region's peoples. During the 1830s, Tolmie distributed smallpox vaccines, shared medical knowledge, and treated Native patients. An examination of Tolmie's journal reveals such instances of interaction with the Nisqually, Puyalup, Suquamish, and Kumamish. In August, 1833, he went on a "botanizing excursion to Mount Rainier." Before he left, he communicated to nearby Native groups that he was "going to Mount Ranier to gather herbs part of which are to be sent to Britain and part retained in case Intermittant Fever should visit us." He anticipated that if the need arose, he would be able to "prescribe [the herbs] for the Indians."[282] "Intermittent fever" was known by the name "fever and ague" among Americans. The symptoms, as described by medical practitioners in the 1830s, included coldness of the body, soreness and stiffness and the limbs. It was often fatal, they believed, because it attacked the liver soon after the first symptoms appeared. There has been much historical debate concerning the translation of these symtpoms

[280] Alexandra Harmon, *Indians in the Making: Ethnic Relations and Indian Identities around Puget Sound* (Berkeley: University of California Press, 1998), 47.

[281] Harmon. *Indians in the Making*, 17.

[282] *The Journals of William Fraser Tolmie: Physician and Fur Trader* (Vancouver: Mitchell Press Limited, 1963), 230.

into twentieth and twenty-first century disease categories, but it seems likely that the references were to malaria. In any case, the illness did not take root in the lower Columbia and Willamette River valleys until the 1830s. In 1830 and 1831, the fever struck the region surrounding Vancouver, attacking both the white and Native populations. Its impact was disproportionately felt by the region's Native peoples, including the Chinook and Clamackas. One white observer wrote that it "has depopulated the country."[283] In contrast, very few white traders and trappers, working for the Hudson Bay Company, died even though many fell ill. In 1832, out of a population of 140 persons at the fort, only 3 did not fall ill with the fever. However there were no casualties listed. This was due to the fact that they had an effective therapeutic remedy at their disposal: quinine, or cinchona bark. Dr. Tolmie's refence here is to dogwood root which he discovered growing in the region and used as a substitute for cinchona bark (quinine) when stores ran low.[284]

Accepting medical care from employees of the HBC, including Dr. Tolmie, did not reflect a belief within Native communities of the superiority of European medicine, nor did it reflect a loss in confidence of their own traditional healers and shamans. Like many other indigenous groups throughout the North American continent, they understood smallpox and many of the new infectious diseases of the region as originating from interactions with whites. This included intermittent fever which struck the region in successive epidemic outbreaks nearly every summer season after 1830. Dr. Tolmie, during an exchange of goods with Indian traders in September of 1833, wrote in his journal:

> Occupied with a Sinnamish hunter & chief who came to barter but broke off. He tells a long story of the arrival of two American ships at Cape Flattery & that the Chiefs threatened to send disease amongst them if they do not trade beaver. It

[283] Boyd, The Coming of the Spirit of Pestilence, 88.
[284] Ibid, 84-102.

> appears that an American Captain who lay for sometime in the Columbia, the season intermittent fever first appeared, is considered by the Indians to have left the malady in revenge for his not receiving skins.[285]

Just as the Ojibwe believed that white diseases could be intentionally transmitted as punishment, so too did the indigenous traders who interacted with Tolmie. Because these were diseases understood as non-Native in origin, it made many more willing to look to white medical practices to treat these.[286] Further, the practice of looking to outside sources of medical care was ingrained in their traditional practices and beliefs. As scholar Alexandra Harmon explains, "it was their custom to consult doctors outside their communities." She argues that the act of soliciting outside medical care should be viewed as a "testimony to their continuing self-confidence; for exposing oneself to powerful spirits was not a deed of the fainthearted."[287]

HBC also offered smallpox vaccines, a practice that they began implementing in the 1830s to help tackle the continuous and often deadly threat of smallpox to their economic activities in British Canada. Smallpox, according to historical estimates, first appeared in the Pacific Northwest in the late 1700s, although it is impossible to rule out the possibility that earlier epidemic outbreaks. HBC offered vaccines not simply to gather favor among trading partners, but also as a prudent economic move. The vaccines helped to insure a continuing supply of native labor. [288]

Relationships established between the HBC and local Native groups were largely replicated by white settlers who began settling near Puget Sound in the 1840s. Many of these settlers, including Arthur Denny, believed from published accounts that the indigenous population of the Pacific Northwest was decreasing. Upon their arrival, however, they

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[285] *The Journals of William Fraser Tolmie*, 238.
[286] Kluger, *The Bitter Waters of Medicine Creek*, 24-25; See also: Hackett. "Averting Disaster," 575-609.
[287] Harmon, *Indians in the Making*, 39.
[288] Hackett, "Averting Disaster," 575-609.

discovered that "indigenous people remained the dominant presence." [289] This population of settlers found itself dependent upon Native peoples for their labor, knowledge of the region, and trade. Because the number of white settlers was so small in comparison to the region's Native population, "they found themselves drawn into the system of exchanges and mutual deference" that existed prior to their arrival.[290] Settlers depended on labor for cutting wood, constructing buildings, and washing clothes. Native people required compensation for their labor and expected exchanges to be mutually beneficial. For example, it was not uncommon for Native peoples to withhold animal skins or food supplies, including large catches of salmon, until they received the items that they wanted.[291] White settlers also relied heavily on Native peoples' knowledge of the land. In 1851, settler R. H. Lansdale employed a laborer to escort him to Snoqualmie Falls and another to help transport his belongings.[292] Arthur Denny relied upon Native knowledge to help him find a place for his livestock to graze when he found himself in a difficult position in the winter of 1852. Denny then helped to direct new settlers to his "discovery" of prairie lands nearby.[293]

The disruption of global trading networks during the winter of 1852 exposed the vulnerability of settlers in the area of Puget Sound and deepened their dependence on local Indians. A community of settlers in Puget Sound relied heavily upon trading vessels that arrived in the port with timber and food supplies. These items reveal the global interconnections that U.S. merchants had established by this period. According to Denny, settlers bought pork and butter that arrived around Cape Horn, flour that originated from Chile, and sugar from China. In

[289] Thrush, *Native Seattle*, 26.
[290] Harmon, *Indians in the Making*, 43-44, 59-62.
[291] Ibid, 26.
[292] Denny, *Pioneer Days*, 25.
[293] Ibid, 30-32.

the winter, however, few trading vessels came and the settlers found themselves with a limited food supply. Denny and a group of settlers traveled by canoe to a Native village on Black river where they traded for food supplies. Denny later reminisced on this experience that while it was a difficult experience, "it demonstrated the fact that some substantial life supporting food can always be obtained on Puget Sound." Denny failed to acknowledge how dependent these earlier US settlers were on Native peoples for their livelihoods and their survival.[294]

From the point of view of settlers, Native labor had the disadvantage of being seasonal. informed Manypenny, "Large numbers of Spokanes, Yakamas, &c., come down in the winter to Vancouver, Portland, and other towns, to seek employment, and their number is yearly increasing." Steven's largest complaint of the current system was not the white settlers relied upon Native labor, but rather that the labor "inconstant."[295]

The labor issue shaped how federal officials envisioned and formulated Indian policy in the region. In 1854, when Isaac Stevens proposed recommendations before conducting treaties, he incorporated what he had learned in his travels. He wrote to Commissioner Manypenny that "the great end to be looked to is the gradual civilization of the Indians, and their ultimately incorporation with the people of the Territory." He recommended the establishment of permanent reservations set aside for the use of Native groups within the region, a similar conclusion drawn by Commissioners Gaines, Skinner, and Allen in 1850. Land, he noted, that should be "good lands," lands for their "exclusive occupation" and "sufficient to pasture their animals." He acknowledged that US Indian policy helped contribute to much of the discontent, violence, and tensions between many groups and the region's white citizen population. He

[294] Denny, *Pioneer Days*, 35-37.
[295] Stevens to Manypenny, September 16, 1854. Annual Report (1854), ARCIA, 247-248

blamed this on the Land Donation Act under which the United States, "contrary to usage and natural right," provided Indian lands to white settlers "without previous purchase from them." Part of the responsibility, then, in creating these reservations, would be to provide the necessary provisions that would allow self-sufficiency, at least in the near future.[296]

Stevens envisioned the creation of reservations as a potential solution to the problem of "inconsistent" season labor. He hoped that U. S. Indian policy would preserve and extend the labor relationships that already prevailed in the region. Towards the end he proposed an apprenticeship system:

> Another measure has been recommended which, under proper regulations, it is believed, would prove of essential benefit to the Indians, and of great convenience to the citizens. This is the establishment of a system of apprenticeship. If a measure could be adopted which would give permanency to the relation of master and servant, and at the same time protect the rights of the latter, the value of Indian labor would be greatly raised. The employment of farm-servants would be especially useful to them, as at the expiration of their term of service they would carry back with them a sufficient knowledge of agriculture to improve their condition at home.[297]

Stevens clearly understood the slippery slope of proposing such a system, which might be more aptly be described as a system of indentured servitude, in the 1850s. Although white citizens would be the main beneficiaries of the "convenience" of permanent labor supply, Stevens appealed to federal officials within the Indian Office by arguing that such a system would also provide benefits to Native peoples. Through their employment as "farm-servants," Native peoples would gain agricultural competency that could further help improve reservation life and contribute to the larger "civilizing" mission of the Indian Office.

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[296] Stevens to Manypenny, September 16, 1854. Annual Report (1854), ARCIA, 247-248.
[297] Ibid.

Stevens discussion of an apprentice system in the Pacific Northwest coincided with an increasingly heated debate throughout American society on the type of labor that would define the western lands recently acquired by the United States and the requirements for their admission as states into the Union. Most political conversations took place over whether free white labor or black slavery would define these regions and reflected growing regional divides over the issue. Prior to the 1840s, the status of slavery was decided by Missouri Compromise, legislation which helped maintain the balance of power in Congress between slave and free states and created a northern boundary line above which slavery could not be extended. However, tensions increased in the 1840s with the dispute over Texas annexation and the acquisition of new territory following the War with Mexico. A growing number of northern politicians saw the expansion of the slave system as an existential political threat while southern leaders identified expansion with their survival as a class.

The Oregon and Washington Territories were considered free territories. A large majority of the settlers were both anti-slavery and anti-black. They did not want African American settlers because they saw them as labor competition. They helped to pass exclusion laws that banned African Americans from living in the Oregon Territory. These laws were not strictly enforced and not all labor in the region could be described as "free." During the 1840s some white settlers came from the slave states, including Missouri. They saw opportunity in the Willamette Valley in the 1840s and brought slaves with them.[298] Nonetheless, black slavery was not an option for most white settlers who turned to Native people to meet their labor needs. Access to Native labor was a priority during this early period of the territory's history.

[298] See: R. Gregory Nokes. *Breaking Chains: Slavery on Trial in the Oregon Territory*. Corvallis: Oregon State University Press, 2013.

A Blueprint for Negotiations: The 1854 Treaty with the Otto, Missouri, and Omaha

On December 7th, 1854, Governor Isaac Stevens met with his assembled commissioners to prepare for treaty negotiations with the Indian tribes in Washington Territory and the Blackfoot Country. Instead of prior experience, the group relied upon the recent treaties concluded between the Commissioner of Indian Affairs, George Manypenny, and the Otto, Missouri, and Omaha. The treaties conducted by Manypenny in 1854 are generally cited by historians as revealing an important shift in US-Indian policy; from removal and relocation to the trans-Mississippi West to the establishment of small, segregated reservations. One year earlier, Manypenny had been tasked by the Secretary of the Interior, Robert McClelland, with overseeing this new direction in Indian policy. The language of the *Indian Removal Act* of 1830 had promised tribes who removed to the trans-Mississippi west that "the United States [would] forever secure and guaranty to them, and their heirs or successors, the country so exchanged with them." The land would revert back to the government on two conditions: if the tribe ceased to exist or if they voluntarily abandoned it.[299] However, the federal government repeatedly broke these promises with Native groups as the need for land outweighed obligations secured in law and treaty documents. This new phase of treaty making, between 1851 until the dissolution of treaty making in 1871, attempted to facilitate the expansion of America's white settler population. Removal to the trans-Mississippi West presented a solution to the nation's "Indian Problem" in the 1830s. However, by the 1840s, white settlers were already eyeing lands in the designated Indian Territory for settlement in the West.

[299] *Indian Removal Act.* Twenty-First Congress. Sess. 1, ch. 148, sec. 2. (May 28, 1830).

The ultimate goal of this new phase of treaty making was to open more lands to white settlement and industrial pursuits. This included farming, railroad expansion, mining, logging, and other industries that would help fuel America's industrial transformation.[300] Rather than relocate Native groups to a designated "Indian Territory," federal officials turned to the reservation system and the concentration of Native groups onto small tracts of land. Treaty terms also included efforts to reform Native peoples both economically and culturally into Christian agriculturalists modeling white, Protestant norms. While this was not something new, treaty provisions now gave federal officials discretionary power to withhold treaty obligations if Native groups refused to comply with government demands.

Manypenny found fault in the western push of America's settler population, but he did not make any efforts to stop it. In fact, he helped the United States acquire 15 million acres of land from Native groups, paving the way for the admission of the Kansas and Nebraska Territories in 1854. Despite his commitment to westward expansion, Manypenny was torn about the impact of these policies on Native groups. He voiced this concern in his Annual Report of 1854: "Their condition is a critical one; such as to entitle them not only to the justice of the government, but to the most profound sympathy of the people. Extermination may be their fact, but not of necessity. By a union of good influences and proper effort, I believe they may, and will, be saved, and their complete civilization effected." Manypenny hoped that the fulfillment of treaty obligations by the government coupled with "diligence, energy, and integrity, in the administration of their affairs" would result in the civilization and preservation of Native peoples.[301]

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[300] For a list of treaties negotiated in the 1850s, see: *Treaties with American Indians: An Encyclopedia of Rights, Conflicts, and Sovereignty.* Volume 1. Ed. Donald L. Fixco. Santa Barbara: ABC-CLIO.

[301] Annual Report (1854), ARCIA, 10-11.

When Manypenny met with the Otto, Missouri, and Omaha to negotiate treaty terms that would affect their confinement to a reservation, he seemed alarmed by their conditions.

> Through the neglect of their former agent, and the delay necessarily occasioned by his rejection by the Senate, and the appointment and qualification of a successor, these Indians have had but little attention during the past season. The Omahas and Pawnees have, it is understood, raised and gathered less than an average crop of corn, but the Ottoes and Missourias are without food for the winter, and all of them are nearly destitute of clothing. When recently in Nebrasksa, I directed the agent to make provision for the necessary wants of the Omahas, and Ottoes, and Missourias; and to proceed at once, with parties of each, to select the reservation provided for in the recent treaties, so that these Indians may be removed early in the spring.[302]

It is telling that Manypenny lay responsibility with an irresponsibile agent when, in fact, he was witnessing the human costs of America's expanding colonial project. The removal and relocation of the Delaware, Iowas, Kaskaskias, Kickapoos, Miamis, Sacs and Foxes, Shawnees, Peorias, Piankashaws, and Weas had created strains on the game population and exacerbated intertribal rivalries. Removal and relocation had not only disrupted those groups who experienced the removal process, but the impact was further felt by those who saw their surrounding lands crowded by these removed parties.[303] Manypenny's inability to see how this confluence of factors had created the condition he witnessed among the Otto, Missouri and Omaha limited his ability to find solutions. He came to the conclusion that the provision of medicines and medical care would address the problems. That conclusion had the added advantage of reinforcing the officials' confidence in American benevolence.

Manypenny was not alone in viewing medical care as a means to ameliorate the conditions that removal had created among Native groups. In 1846, Acting Superintendent William Armstrong reported his despair when he visited a group of Choctaw that he had worked

[302] Annual Report (1854), ARCIA, 7.
[303] Weeks, *Farewell, My Nation*, 79-81.

with prior to their removal. It was a group that he expressed a great fondness and sympathy for, most likely due to the large numbers who converted to Christianity. "As I had taken considerable pains to persuade them to remove, it may be conceived that I felt greatly shocked, on my recent return to this place, to find them all, without an exception, greatly reduced by disease." Reports from agents told a similar story. Cyrus Byington, Indian agent for the Choctaw Agency, wrote to Captain William Armstrong, Acting Superintendent for the Western Territory, that treating the sick had become one of his regular duties. He wrote: "From necessity, I am called to be much employed for the relief of the sick, there being no physician nearer than Fort Towson." He described the region as a "sickly land" requiring him to assume the role of physician among his neighbors as well among his own family who had also fallen sick with fever.[304]

Unlike Manypenny, Armstrong found fault with the conditions of removal, even though he had helped oversee its implementation. He acknowledged the federal government's role in creating the conditions that caused so much suffering. Removal, observed Armstrong, had been undertaken "against their own inclination, at the solicitation of the government." Prior to removal, the people as well as the land was "healthy." In fact, "[s]ome of them were… the most hearty, robust looking people I have ever seen." He was referring to small group within the Choctaw population whom he identified as "distinguished" by their conversion to Christianity. This conversion had been achieved through the conversion of a respected member from within the community, Toblee Chubbee. According to Armstrong, Chubbee used his "considerable" influence within the community to induce others "to lead sober and industrious lives, to abandon the habits of Indians, and to dress and live like white people." They were, in fact, so dedicated to maintaining these gains that they were induced to remove only after they were assured of the

[304] Cyrus Byington. September 22, 1843. Annual Report (1843), ARCIA, 339-340.

presence of "schools, churches, and other improvements" in their new lands. For this "distinguished" group, Armstrong was incensed that the government provided medical care during the removal process but failed to provide any medical assistance afterwards. "This," he concluded, "I cannot but regard as wrong." [305] Armstrong saw disease and sickness coupled with absence of federal health care services as impediments to the overarching project of Native Christianization in the trans-Mississippi West.

Superintendent Thomas Harvey made a similar report to the Commissioner of Indian Affairs. He explained that during the fall of 1846, "the border tribes of Indians suffered severely from autumnal fevers, which prevailed to an unusual degree in the west." He believed that "these fevers, in the hands of the physicians, readily yield to medical treatment; and, indeed, with the grand specific, quinine, at command, persons of ordinary intelligence, in the absence of the physician, manage them with a good deal of success." The absence of medical provisions coupled with what he identified as "the irregular habits of the Indians," often resulted in high mortality rates. He used this example to argue for increasing access to government physicians or, at the minimum, distribution of medical supplies.[306]

Manypenny's decision to include medical care in the provisions of the treaties negotiated with the Otto, Missouri, and Omaha was based on precedent. Treaties conducted with the Ho-Chunk in 1832, the Saganaw band of Chippewa Indians in 1837, the Mdewakanton Sioux in 1837, and the Sauk and Fox Indians in 1842 had similarly contained provisions for physicians' care in exchange for land cessions. Henry R. Schoolcraft, who negotiated the treaty terms with the Saganaw band of Chippewa Indians in 1837, included provisions for access to a physician

[305] William Armstrong, Acting Superintendent, to Hon. W. Medill, Commissioner of Indian Affairs. October 10, 1846. Annual Report (1846-1847), ARCIA, 55- 56.

[306] Thomas Harvey, Superintendent of Indian Affairs to Hon. William Medill, Commissioner of Indian Affairs. September 5, 1846. Annual Report (1846), ARCIA 70.

and vaccine matter for a period of 5 years. Schoolcraft explained these decisions in a letter following treaty negotiations:

> The minor provisions of the treaty, and the precaution for ensuring its faithful execution, are such as resulted from the obvious condition of the tribe, and it is believed, will be mutually beneficial to the Indians and to the Government. The whole is the result of care, and deliberate discussion with a full delegation of the several bands, and it is therefore transmitted, with confidence, for the consideration of the President and Senate.[307]

Schoolcraft's Annual Report of 1840 suggest additional reasons for the provision of medical care in the Treaty of 1837. He believed the benefits far outweighed the costs associated with employing a physician to attend the medical needs of those under his supervision. "The Indians not only appreciate the medical art, and have great faith in it, but are pleased with the attention of physicians, often when the cause of complaint is but slight. Their employment keeps up a good understanding with them." Schoolcraft saw physicians as useful to furthering federal interests and establishing positive lines of communication between the two sides. He lamented that so little had been done to extend these advantages further. "It is a matter of regret," he wrote, "that so little attention has been bestowed on the subject in the formation of treaties, and that so little is actually set apart for their support."[308] Schoolcraft appears to have been more pragmatic – motivated less by humanitarian concerns than by his belief in practical benefits to be gained from the provision of medical care.

Manypenny's decision to provide provisions for medical care in two negotiated treaties in 1854 built upon the prior work of federal agents who had, under different circumstances and with

[307] Henry R. Schoolcraft, Superintendent of Indian Affairs, to Carey A. Harris Esq., Commission of Indian Affairs, War Department. January 16, 1837. *Ratified treaty no. 219, documents relating to the negotiation of the treaty of January 14, 1837, with the Saginaw band of Chippewa Indians*. (Washington, D.C.: National Archives, 1837). http://digital.library.wisc.edu/1711.dl/History.IT1837no219

[308] Henry R. Schoolcraft, Acting Superintendent Indian Affairs, Michigan, to Hon. T. Hartley Crawford, Commissioner of Indian Affairs, Washington. Annual Report (1840), ARCIA, 350.

different groups, found success in providing provisions for medical care during the treaty negotiation process. Stevens and his committee applied the lessons of earlier agents, superintendents, and reform-minded individuals, and applied them to propose a treaty to the multiple tribes surrounding Puget Sound. The draft outline contained the following provisions: the cession of all tribal lands to the United States in exchange for a tracts of land "reserved to the use of said Tribes," language that guaranteed the tribes would remove and settle on these reservations within one year after ratification of the treaty. In exchange, a sum of money would be paid in annual installments, decreasing at a rate of 5 percent each year. To help with the transition onto the reservations, the federal government promised to build homes for the chiefs and to "indemnify settlers, if any, on lands reserved." Provisions were also outlined for the President to "assign lots to heads of families" and maintain at the central agency an agricultural school. And last, but not least, the treaty template contained a line that also included provisions for "medical attendance." It seems that by 1854, medical care had become a standardized part of treaty negotiations.[309]

"To overcome their objections": The Treaty of Medicine Creek

On December 26th, Stevens met with approximately six hundred and thirty Nisqually, Puyallup, Squaxin, and Steilacoom people to negotiate the first of many treaties. The treaty was held near a sacred site of the Nisqually people, a stream they called She-nah-nam (translated as Medicine Creek). Traditional healers would come to the stream to draw upon its healing

[309] Ibid.

powers.[310] After reading the treaty, Isaac Stevens and the Commission asked the chiefs present to sign the treaty and distributed gifts among the attendees.

At an evening session, the Commission discussed the treaty terms and detailed what provisions would be provided the tribes, which monetarily could not surpass the annuity payments of the first year ($20,000). When it came to discussing the question of employing a physician, who would reside and treat patients at the Central Agency, it was decided by vote that the position was necessary. A previous letter indicated that these terms had helped assuage at least the Umpqua people to become more amenable to the treaty terms: "together with the prospects of being provided with a home, a physician for their aged and infirm, protection for their women and children, as well as the prospect each affored by cultivating the soil, of an abundance to guard against hunger; indused the more considerate to listen favorable to our proposals [sic]."[311] He continued, "The individual interests in spots of ground, with the prospect of being aided in the improvement of them, and the proposal to establish schools and a hospital among them contributed very much to overcome their objections."

From an indigenous perspective, there were benefits to gaining access to medical services. These groups had only to draw upon their past experiences with the Hudson Bay Company, and director William Fraser Tolmie in particular, to see that medical exchange with white physicians brought some benefit to their communities. From the perspective of Stevens and the other federal officials involved in treaty negotiations there were clearly benefits to the state in extending these services. For one, it seemed helpful in securing land cessions. But

[310] Reddick and Collins, "Medicine Creek to Fox Island," 374.

[311] "Records of the Proceedings of the Commission to hold Treaties with the Indian Tribes in Washington Territory and the Blackfoot Country." *Ratified Treaty no. 281, documents relating the negotiation of the treaty of December 26, 1854, with the Nisqualli, Puyallup, and Other Indians*. (Washington, D. C.: National Archives, Dec 26, 1854) http://digital.library.wisc.edu/1711.dl/History.IT1854no281

another factor should be taken into consideration: Stevens viewed these Native groups as an important labor source.[312] For one, their mastery of the region and the harbors was useful, especially when it came to transportation of items by waterway. He also noted that men and woman both performed useful labor that could be utilized by white settlers. Ideally, Stevens saw the creation of reservations not simply as a means to open up land for white settlement, but also importantly as a labor pool for whites to draw upon even if only until more white settlers arrived to the region.[313]

If we apply Stevens' understanding or at least hopes that these reservations could provide a labor force, it becomes possible to view the significant provisions (at least in comparison to other treaties) for medical care as a means to support a healthy labor force. The final breakdown for estimate expenditures for employees for the first year at the Central Agency included: one surgeon at $1500, one teacher and wife at $1500, one farmer at $750, one blacksmith at $750, and other "employees" at $1200 (see table 2). The estimated budget also included provisions for medicines at $1000. Altogether, those funds designated for medical purposes equated to $2500 or 12.5% of the $20,000 to be expended at the central agency for the first year.[314] This was a significant portion of the funds and an increase in the type of medical provisions offered by the federal government.

[312] Reddick and Collins, "Medicine Creek to Fox Island," 376-377.
[313] Ibid, 378.
[314] "Records of the Proceedings of the Commission to hold Treaties with the Indian Tribes in Washington Territory and the Blackfoot Country." *Ratified Treaty no. 281, documents relating to the negotiation of the treaty of December 26, 1854, with the Nisqualli, Puyallup, and Other Indians*. (Washington, D.C.: National Archives, Dec 26, 1854). http://digital.library.wisc.edu/1711.dl/History.IT1854no281

Table 4.2: Estimated Expenditures for the First Year ($20,000) at the Central Agency

Description of Funds	Allotted Funds per year
1 Surgeon	1500.00
1 Teacher and Wife	1500.00
1 Farmer	750.00
1 Blacksmith	750.00
Employees	1200.00
Medicines	1000.00
Support of 200 children at school	5000.00
Necessary Buildings	5000.00
Materials, Tools, Etc.	2550.00

Source: "Records of the Proceedings of the Commission to hold Treaties with the Indian Tribes in Washington Territory and the Blackfoot Country." *Ratified Treaty no. 281, documents relating the negotiation of the treaty of December 26, 1854, with the Nisqualli, Puyallup, and Other Indians*. (Washington, D. C.: National Archives, Dec 26, 1854) http://digital.library.wisc.edu/1711.dl/History.IT1854no281

A Standardized Model Emerges: Medical Care and the Creation of the Reservation System in the Pacific Northwest

These lessons were applied to subsequent treaties which continued at a rapid pace throughout the winter of 1855. When Governor Stevens met with the Duwamish and Suquamish people in early January of 1855, he spoke to assembled gathering of members of these groups and reviewed his prior promises of houses, clothing, and construction of a school. He asked Chief Seattle if there was anything that was missing: "Does anyone object to what I said? Does my venerable friend Seattle object to what I have said. I want Seattle to give his voice to me and to his people." It is unclear what words Seattle spoke to the interpreter as his response is not included in the treaty council transcripts, but Stevens' response is telling. He spoke, "My friend Seattle has reminded me of the thing which was in my heart. You shall have a

physician and I trust one that will cure your souls as well as your bodies."[315] The treaty terms were then read and translated, gifts distributed, and the treaty signed. This treaty, known by the name Treaty of Point Elliot, included promises for medical care. The treaty stated, "the United States finally agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them." These expenses would be incurred by the United States, "not deducted from the annuities."[316]

Not all Native groups, however, placed primacy on gaining access to medical care. Just a few days after concluding the Treaty of Point Elliot, Stevens arrived in Neah Bay to negotiate a treaty with the Makah people. Stevens, well-practiced in negotiating land cessions, discussed his success at negotiating with the tribes of Puget Sound "for their lands." In exchange, he highlighted the generous provisions offered on behalf of the "Great Father": schools, farms, and a physician. Kal-chote's response is telling. He identified himself not as the sole leader of the Makah, but rather "a small chief" among a group of four leaders, three of whom had died. Of utmost importance was securing fishing and whaling rights for his people. Stevens responded that federal provisions could include oil kettles and fishing apparatus to help in these activities, but that "whites should fish also." The reason, he told them frankly, was that "many whites were coming to the country, and that he did not want the Indian to be crowded out." The others members in the treaty council did not seem to mind sharing fishing rights. The treaty terms were read, signatures acquired, and gifts distributed.[317]

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[315] Record of Proceedings by Gov. Isaac I. Stevens, Treaty Commissioner, to Commissioner of Indian Affairs, May 4, 1855. *Ratified treaty no. 283, documents relating to the negotiation of the treaty of January 22, 1855, with the Dwamish, Suquamish, and other Indians.* Washington, D. C.: National Archives, January 22, 1855 UWDA http://digital.library.wisc.edu/1711.dl/History.IT1855no283

[316] Treaty with the Dwamish, Suquamish, Etc., 1855, Kappler, *Indian Treaties*, 672.

[317] Record of Council Proceedings, January 29-31, 1855. *Ratified treaty no. 286, documents relating to the negotiation of the treaty of January 31, 1855, with the Makah Indians.* (Washington, D.C.: National Archives, 1855). http://digital.library.wisc.edu/1711.dl/History.IT1855no286

Isaac Stevens and Joel Palmer came together in 1855 when they negotiated treaties with the Nez Perce, Walla Walla, and Cayuse people since the groups occupied lands in both the Washington and Oregon territories. These groups provide a different perspective from that of the coastal groups Stevens' began negotiating treaties with first. The Nez Perce, or Nimiipuu (the Real People), who occupied the land comprised of the Columbia Plateau, the Kill Devil and Wallowa Mountains, and the Bitterroot Mountains (present day northeastern Oregon, southeastern Washington, and north central Idaho), remained economically independent during these decades. Like many other Native groups, their lifeways revolved around utilizing the resources of the land. Gifted horsemen, they crossed the Bitterroot Mountains eastward to hunt buffalo on the Great Plains. In the summers, they fished for salmon, trout, and whitefish in the Snake, Salmon, and Clearwater rivers.[318] Their first interactions with whites did not occur until Lewis and Clark journeyed through their lands in the early nineteenth century. Publications of their trip and news of what they discovered along their journey helped encourage greater American and British activities. Their visit was quickly followed by the arrival of fur trading companies. Fur trading companies, who had depleted populations of beaver, found opportunity in the upper Missouri and the Pacific Northwest and looked to incorporate Native groups, including the Nez Perces, as hunters in this economic network.[319] The Nez Perce, who did not regularly trap beavers, rejected these offers by both American and British fur traders; but it did initiate a series of changes to the region that led to an increased American and British trading presence.

[318] See: Elliott West, *The Last Indian War: The Nez Perce Story* (Cambridge: Oxford University Press, 2011), 1-14; J. Diane Pearson. *The Nez Perces in the Indian Territory* (Norman: University of Oklahoma Press, 2008), 9-10.

[319] West, *The Last Indian War*, 22-25

While the Nez Perce rejected offers to hunt and collect beaver pelts, they did become involved in a trading system with Americans beginning in the late 1820s. Successful horsemen and breeders, Nez Perce horses were highly valued and sought offer by American traders. Participation in this trading system worked to the advantage of the Nez Perce who were able to navigate between the imperial rivalries of both the British and Americans and use it to their advantage. In exchange for their highly coveted horses, the Nez Perce gained access to guns, clothing, blankets, ammunition, and other tools including knives, fishhooks, and pipes for smoking tobacco.[320] Thus, while nearby neighbors became intertwined in European and American fur trading enterprises in the region, including the Cayuse, the Nez Perce retained their economic autonomy in a system of trading with Americans for at least a time.

Provisions found useful in negotiating treaties with the Coastal tribes were applied in a more standardized manner, with little discussion provided in treaty documents about the nature of their inclusion. The complicated history of medical exchange with these groups support the argument that these were not services highly valued by these groups. The Whitman Massacre is one example of this. Protestant missionaries to the region led to rising tensions and increased resentment among the Nez Perce, as well neighboring groups including the Cayuse. The Nez Perce's and Cayuse's relationship with Dr. Elijah White, medical missionary and US Indian sub-agent, exemplifies this shift in imperial dynamics in the region. Further, it reveals the very different circumstances under which the Nez Perce and the Cayuse (who interacted with Dr. Whitman) engaged in medical exchange. Here, medicine was intimately tied to Christianization and conversion efforts.

[320] Ibid, 24-26.

The events of the Whitman Massacre reveal the intersection of white settler encroachment, disease and violence that occurred between white settlers and Native peoples in the region. An outbreak of measles in 1847 brought these tensions to a head and is considered by historians the most immediate source of resentment by the Cayuse people that led to the outbreak of violence against Dr. Whitman and others at the mission. As part of his missionary efforts, Dr. Whitman provided medical care to Native peoples, most likely to curry favor as an accompaniment to his conversion efforts. However, the impact of this epidemic outbreak was devastating and led to a large loss of life for the Cayuse population. In total, it is estimated that the Cayuse population was reduced by 40%, nearly two hundred deaths within a population that might have numbered five hundred at the time of the outbreak. They blamed Dr. Whitman for the epidemic outbreak and killed thirteen people at the mission.[321]

This complicated past had no bearing on the treaty terms negotiated with the Nez Perce, Cayuse, or Walla when it came to medical provisions. In the three treaties negotiated by Palmer and Stevens with these groups, all received funds for the construction of a hospital, its upkeep, provisions for furniture, medicines, and the services of a physician. These treaties demonstrate how medical care, the employment of a physician, and the construction of a hospital emerged as characteristic features of the reservation system. The ratification of the treaty, however, did not end disputes and tensions with these groups. Rather, growing factionalism, building tensions, and the outbreak of war soon followed.

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[321] Boyd. *The Coming of the Spirit of Pestilence*, 145-149.

The series of treaties negotiated in the Pacific Northwest between 1854 and 1855 led to a broad expansion of the federal Indian health care system that first emerged in the 1830s during the early period of antebellum removal. Federal commissioners Isaac I. Stevens, the territorial governor of Washington Territory, and Joel Palmer, Superintendent of Indian Affairs in Oregon, negotiated eighteen treaties with the indigenous tribes of the Pacific Northwest that secured US title to the region. Nearly all of these treaties contained provisions for medical care, the purchase of medicines, and for some, the construction of hospitals at the central agency of their intended reservation. Palmer and Stevens drew upon previous treaties that included provisions for medical care in exchange for land cessions and applied these lessons to their treaty negotiations with seeming success as they negotiated treaties with tribes on the coastal regions of the Oregon and Washington Territories. By the end of the decade, provisions for medical care emerged as a standardized practice of the creation of the reservation system and one of its defining features.

Although these groups might have expected these provisions to provide medical relief to their communities, federal health care provisions ultimately advanced the interests of the state. Of the nine treaties negotiated by Stevens, only the Treaty of Medicine Creek, signed with Nisqually, Puyallup, Steilacoom, Squawksin, S'Homamish, Steh-chass, T'Peeskin, Squi-aitil, and Sa-heh-wamish tribes, received the services of a physician soon after treaty negotiations ended. The other eight treaties were delayed by the Senate until they were ratified in 1859, and many did not see any benefits of promised provisions until 1861.[322] The same delay did not reflect the rapid settlement, sale, and distribution of lands to white settlers and railroad interests. These treaties ultimately facilitated Native dispossession, the creation of the reservation system,

[322] James R. Masterson. "The Records of the Washington Superintendency of Indian Affairs, 1853-1874." *The Pacific Northwest Quarterly* 37, no 1 (Jan., 1946): 41.

and led to the broad expansion of federal power into the North American West at a rapid pace in the 1850s.

Chapter Five

Reconstructing the System: Native Peoples, Government Physicians, and the Bureaucratization of Federal Indian Health Care Services

After the Civil War, a more aggressive state emerged that sought to "reconstruct" the relations of Native peoples to the federal government and their role within American society. During the period known as Reconstruction, federal officials sought to end tribal sovereignty, extend congressional control into tribal matters, and remake Native peoples according to white, middle-class Protestant ideals. One of the ways they did this was ending the practice of treaty making as a means of negotiating with Native groups. In an appropriations bill, under instructions for the distribution of annuities to the Yankton Sioux, Congress announced that "hereafter no Indian nation or tribe within the territory of the United States shall be acknowledged or recognized as an independent nation, tribe, or power with whom the United States may contract by treaty."[323] Just two years prior, Indian Commissioner Ely. S. Parker explained that negotiating a treaty "involves the idea of a compact between two or more sovereign powers, each possessing sufficient authority and force to compel a compliance with the obligations incurred." "The Indian tribes," he concluded, "are not sovereign nations."[324]

[323] An addendum was attached to the 1871 status change: "nothing herein shall be construed to invalidate or impair the obligation of any treaty heretofore lawfully made and ratified with any such Indian nation or tribe." Thus, while this change in status eliminated future treaty obligations and federal commitments to Native groups, it did ensure continued access to services already secured. For many, this included continued access to federal health care services, included in many ratified treaties made prior to 1871. *Acts and resolutions of the United States of America passed at the third session of the forty-first Congress and the first session of the forty-second Congress: December 5, 1870-April 20, 1871* (Washington, D.C..: Govt. Printing Office, 1871), 197.

[324] Ely S. Parker, Report of the Commissioner of Indian Affairs, December 23, 1869. Annual Report (1869), ARCIA, 6.

This formally recognized what many had believed for some time about the status of Native peoples within the nation[325]

Changes during the period of Reconstruction also extended into the Office of Indian Affairs and, specifically, into matters related to Native health. At the end of the Civil War, the Office of Indian Affairs had yet to develop a comprehensive system for providing medical care and services on reservations. Suggestions for broad federal policies emerged during the following decade and included United States Indian Agent R. A. Wilbur's recommendation in 1873 that each reservation should be organized with a medical department and the presence of a physician.[326] These recommendations were rooted in processes initiated during the Civil War years that proved just as traumatic and devastating to many Native groups as removal had been in the 1830s. In 1873, Indian Commissioner Edward P. Smith, a Protestant pastor from the Northeast and a Republican appointee of President Grant, showed interest in addressing the sickness, suffering, and death occurring across reservations. He had, in fact, just spent several years working with the American Missionary Society in the post-Civil War South organizing relief efforts and establishing black colleges for freedpeople. Smith brought the work of Reconstruction to his new position in the Indian Office and oversaw the bureaucratization of the nation's nascent federal Indian health care system into a separate Medical and Educational Division. Smith not only represents a link between Reconstruction era policies among freedpeople in the South and Native peoples in the West; he also reveals how state building policies of the Republican party during Reconstruction extended into Indian country. [327]

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[325] *Acts and resolutions of the United States of America passed at the third session of the forty-first Congress and the first session of the forty-second Congress: December 5, 1870-April 20, 1871* (Wash.: Govt. Printing Office, 1871), 197.

[326] R. A. Wilbur, "Suggestions in Regard to the Management of These Reservations," Annual Report (1873), ARCIA, 64.

[327] For scholarship that examines the changing relationship between Native peoples and the federal government during the period of Reconstruction, see: Christopher B. Bean. "Who Defines a Nation?: Reconstruction

The creation of the Medical and Education Division led to substantive changes in the relationship between Native peoples and government physicians and the role of these physicians within the administrative state. Physicians, now working on reservations across the American West, became much more important state intermediaries in the post-Civil War decades. Federal officials hoped physicians would help supplant the power and influence of "medicine men" who were important figures in many Native communities. The effort to undermine the authority of medicine men was part of the larger project of assimilation. Second, federal officials enlisted physicians to monitor Native populations. The government tasked physicians with collecting vital statistics about Native peoples, a practice that reflected the growing power of an expanding state.[328] James C. Scott argues that the premodern state lacked knowledge that it could use for its own purposes, particularly when it came to its' subjects. The modern state emerged, in part, by monitoring and recording information that it could use to make better use of people, as a labor force, and the land, including its natural resources.[329] Doctors collected data on rates of sickness, morbidity, and mortality on reservations. In so doing they helped construct a narrative of ill health across reservation communities. Rather than use this quantitative and qualitative data to re-examine federal Indian policies, federal officials used statistics as evidence to support a more active custodial role for the state. Examining the changing role of physicians, both their role within the state and their relationship to Native peoples, adds to historical scholarship on the

in Indian Territory." The Civil War and Reconstruction in Indian Territory. Ed. Bradley R. Clampitt. (Lincoln: University of Nebraska Press, 2015), 110-131; Hahn, *A Nation Without Borders*, 280-316. For a thorough discussion on the statist policies of the Republican Party during Reconstruction, see: Foner, *Reconstruction.*

[328] Drew Gilpin Faust argues that "statistics emerged in close alliance with notions of an expanding state, with the assessment of its sources, strength, and responsibilities." Faust, *This Republic of Suffering,* 251.

[329] James C. Scott, *Seeing like a State: How Certain Schemes to Improve the Human Condition Have Failed* (New Haven: Yale University Press, 1999), 51-52.

national reach of Reconstruction-era policies and their impact on indigenous peoples' relationship with the state.

"the red man of America is passing away": A Post- Civil War Narrative of Ill-Health and Population Decline Emerges

Shortly after the Civil War ended, federal officials and congressmen began circulating a narrative that focused attention on Native ill health and population decline. In 1867, a Congressional report was published that painted a bleak picture of Native health across the country. This report represented the culmination of work that began in March of 1865 when both houses of Congress commissioned a joint committee to investigate "the condition of the Indian tribes and their treatment by the civil and military authorities of the United States." Over an eighteen-month period, the Committee conducted interviews, gathered information from army officials and Indian agents, and in January of 1867, submitted its findings on the "true condition of the Indian tribes."

Officials sent to inquire into the condition of the Indians in different regions agreed that Native peoples were "rapidly decreasing in numbers," but they differed concerning the causes of the decline. General Pope attributed declining native populations to disease, warfare, cruelty by whites, reductions in game populations, and "unwise policy of the government, by inhumane and dishonest administration of that policy." But General Pope was in the minority. General John T. Sprague offered another explanation. He believed that population decline resulted simply from contact with white people. As Sprague put it: "So soon as Indians adopt the habits of white men they begin to decrease, aggravated by imbibing all the vices and none of their virtues." General

Carlton agreed with Pope's assessment that disease and warfare were contributing to population decline, but added racialized language echoing social Darwinist arguments of the natural evolution of races. In his view, "the causes which the Almighty originates, when in their appointed time He wills that one race of men – as in races of lower animals – shall disappear off the face of the earth and give place to another race, and so on, in the great cycle traced out by Himself…the red man of America is passing away!"[330] These narratives deflected responsibility for the conditions on reservations to racialized assumptions about Native bodies. And all of these officials, including Pope, concluded that greater federal intervention was necessary to improve the lives of Native people.

In fact, the Congressional Report of 1867 painted an accurate picture of the bleak conditions on many reservations following the Civil War. The Ho-Chunk people, whose condition drastically deteriorated during the Civil War years, exemplified the situation of many Native groups. Their situation was not the product of their behaviors or customs, what General Carlton inferred was inherent in their Indianness. Rather, it reflected the human costs of U.S.-Indian policy both during and after the War.

The experiences of the Ho-Chunk during the Civil War years rivaled their experiences during removal from their ancestral homeland decades prior in terms of the death, sickness, and suffering that it produced. By 1855, the Ho-Chunk people had made great gains in overcoming the negative impact of removal era policies. They had negotiated a new treaty to secure lands better suited to their needs in the Blue Earth River valley and enacted a series of reforms to reconstruct community cohesion. These efforts helped address both the physical and spiritual

[330] "Condition of the Indian Tribes." Report of the Joint Special Committee. Appointed under Joint Resolution of March 3, 1865 (Washington, D.C.: Government Printing Office, 1867), 3-4.

needs of individual members and the health, well-being and unity of the group as a whole. By 1865, the Ho-Chunk were expelled from the state and forcibly removed to Crow Creek Reservation in the Dakota Territory. This removal and the conditions at Crow Creek led to increased rates of sickness, suffering, and death. Faced with the threat of starvation on these new lands, the Ho-Chunk people fled to the Nebraska Territory to the South and negotiated a new treaty in 1865 to remain on a portion of the Omaha people's lands. Many others fled to their ancestral homelands in Wisconsin. By the time the war came to an end, the Ho-Chunk were a fractured people and in a position of dependency to the state.

The first changes to impact the Ho-Chunk were the withdrawal of federal troops from neighboring forts and their reformation into recruitment sites and training centers for Union forces. For white settlers, the presence of multiple forts - Fort Snelling, Fort Ripley (1849), Fort Ridgley (1853), and Fort Abercrombie (1857) - helped assuage long-standing public fears of living in a region with a significant Native population, including the Dakota, Ojibwe and the Ho-Chunk people. For Native groups in the region, these forts helped regulate interactions between settlers and Native peoples and prevented white settlers encroaching upon indigenous lands. Tensions had arisen with the Ho-Chunk's arrival to the region in the 1850s. Many white settlers in the southern part of the Minnesota Territory, particularly those who had set up homesteads in the Blue Earth river valley, took issue with the boundaries established between the Ho-Chunk and the federal government. Mr. Sargent highlighted the tension between the county's first white settlers and the arrival of the Ho-Chunk in an article originally published in *Pioneer and Democrat* and shared with readers of *The Mankato Weekly Record* in July of 1859. According to the writer, the first settlers to the region arrived in 1852, built the first cabins and marked out the limits of the town of Mankato that summer. Initially the town consisted of "more than ten

persons" in 1852, but grew to 3,629 by 1857. The arrival of the Ho-Chunk, according to Sargent, was "a great blight upon the interest and growth of our country." Further, he and many others believed that the Ho-Chunk's arrival was an act of dishonesty. The reservation "was not to approach nearer the Minnesota river than where the Le Sueur empties into the Blue Earth. It was represented in Washington that this point was at least *thirty-five* miles from Mankato. By this unfortunate mistake or unpardonable misrepresentation, these Indians were placed within…and [have] become the possessors of six and a half townships of land almost in the heart of the county."[331] These boundaries necessitated the removal of twenty-one families who had set up homesteads on what many considered to be "the very best farm lands in the country."[332] The displacement of white settlers would serve as a source of ongoing tension between the Ho-Chunk people and their nearby neighbors in the southern region of the Minnesota Territory. The presence of federal troops at the forts helped temper these local tensions and provided the Ho-Chunk with protection from white settler hostilities.

The withdrawal of troops made the Ho-Chunk more vulnerable to efforts by Mankato residents to strip away at the Ho-Chunk's land base and white encroachment. White settler migration steadily increased to the Minnesota Territory throughout the 1850s. The white settler population grew from 6,077 in 1850 to 172, 023 by 1860, a 2,730% overall increase of which foreign born migrants made up nearly 29% of this burgeoning population.[333] Certain factors facilitated the movement of these settlers: railroads, canals, and road improvements. It was

[331] "Blue Earth County – First Settlement, Etc." Tuesday, July 2 1859 vol 1 no 1 (Mankato Record; Minnesota Historical Society)

[332] Thomas Hughes, *History of Blue Earth County and Biographies of Its Leading Citizens* (Chicago: Middle West Publishing Company, 1901), 59. Hughes explained that the reservation actually cut through six townships that had recently been established nearby. Hughes attributed the displacement of these homesteading families as a case of false representation. Congress, supposedly, had been told that the area designated for the Winnebago was farther from the nearby town of Mankato than it was in actuality.

[333] Theodore C. Blegen, *Minnesota: A History of the State* (Minneapolis: University of Minnesota Press, 1975), 175.

possible to take a train from New York to Rock Island, IL and then take a steamboat to St. Paul, where many new settlers first arrived in the state. In the summer of 1855 alone, 30,000 people arrived by steamboat in St. Paul.[334] Great efforts had been made by the territorial legislature to attract people to the region. A special exhibit was displayed at the world' fair in New York in 1853 and other efforts, including pamphlet distributions to newly arrived immigrants in New York, helped to bring settlers into the region.[335] These efforts helped Minnesota gain admission as a state in 1858.

These policy changes were felt almost immediately, from the increased poverty of the tribe to the increased hostility and violence of the nearby white population towards the Ho-Chunk. The agent explained, "The more thickly settled the country around them becomes the less opportunities they have for procuring wild game, wild rice, berries, &c., their former and original means of livelihood." Their agent admitted, "The hostile feelings of the white people are so intense that I am necessitated to use extra efforts to keep the Indians upon their own lands, for the reason that I have been notified by the whites that the Indians will be massacred if they go out of their own country." The agent further noted that only a few days prior "a Ho-Chunk was killed while crossing the Mississippi river for no other reason than that he was an Indian, and such is the state of public opinion that the murderer goes unpunished."[336]

This was compounded when the federal government shifted its attention away from fulfilling treaty obligations to Native groups throughout the country. Annuities and provisions promised in treaty negotiations, obligations agreed upon in exchange for land cessions, went unfulfilled. The withholding of food distributions was critical to the outbreak of the US-Dakota

[334] Ibid, 180.
[335] Ibid, 180-181.
[336] St. A.D. Balcombe to Col. Clark W. Thompson, Superintendent Indian Affairs, St. Paul. September 15, 1862. Annual Report (1861), ARCIA, 92.

War in 1862. The Dakota Sioux, comprised of the Mdewakanton, Sisseton, Whapeton, and Wahpekute bands, desperate for food after a failed crop season in 1861, and frustrated with civilization efforts, white encroachment, conflicts with unscrupulous traders, and abrasive Indian Office administrators in the region who refused to distribute food stores as promised in a treaty, brought war to the white settlers nearby. The war, which lasted six weeks, resulted in the deaths of hundreds of white settlers and ended with the mass execution of thirty-eight Dakota men and the expulsion of all Native groups from Minnesota.

Despite the Ho-Chunk' neutrality during the US-Dakota War of 1862, Minnesotans, long desirous of expelling all Native peoples from the state, pushed for their expulsion as a means to settle once and for all the contentious battle over state land that had dominated life throughout the 1850s. In 1863, Congress passed the Winnebago (Ho-Chunk) Removal Act and removed the Ho-Chunk and Sioux to the Crow Creek Reservation in the southwestern Dakota Territory. Officials expected this "small, previously uninhabited area near the mouth of Crow Creek" to support the roughly three thousand members of both tribes.[337] It was an unfamiliar land ill-suited to the lifeways and practices for both groups who had long relied on access to lakes, streams, and rivers for subsistence. Further, it was a region ill-suited to the type of agricultural production that Indian agents, missionaries, and federal employees sought to replicate on reservations throughout the country.[338]

Resettlement took a heavy toll on the Ho-Chunk. They travelled nearly two-thousand-miles to their new home by steamboat over the Mississippi and Missouri Rivers. The three boats hired for the journey all experienced great difficulties due to the low water levels during

[337] William E. Lass, "The Removal from Minnesota of the Sioux and Winnebago Indians." *Minnesota History* 38, no 8 (Winter 1963), 363.

[338] Collette A. Hyman, "Survival at Crow Creek, 1863-1866," *Minnesota History* 61, no 4 (Winter 2008), 153.

the late spring. The "Eloian" sank after it hit a sandbar that ripped a 30-foot hole along the hull. The "Favorite," carrying three hundred and fifty Ho-Chunk passengers, was deemed inoperable after hitting an exposed reef at Little Rapids.[339] When the Ho-Chunk arrived at Fort Randall, they had to endure an additional journey up the Missouri River to their new, adjacent reservations in Crow Creek, the last group arriving on June 24th aboard the "Florence."

John P. Williamson described in the letter to his father the sickness and suffering among the Ho-Chunk people upon their arrival. He attributed part of these problems to the absence of medical attendance. He explained, "These Indians need a good doctor very much and the necessary supplies for sick folk. There have been 28 died since we started… they had had nothing for sick folks- so they have been pretty bad off.[340] Williamson noted that the move was especially difficult on the children and was compounded by a lack of food supplies. He explained:

> A child takes sick with diarhea or dysentery or sore throat. There is no medicine to be had any place. Perhaps they dig up some root & give it which is more apt to make it worse than better. But if it does overcome the disease it is very weak and needs some light diet. But there is nothing to be had but pork & flour & corn, which great many won't stand & so they die. I don't' think many white children would grow up either under the same circumstances. Sometimes by hand begging I can get a pint of rice for some one but I hate to be begging all the time, and there is a great deal of sickness.[341]

For Williamson, there was a helplessness in witnessing the suffering of the Ho-Chunk people and having little to nothing at his disposal to help alleviate it. The lack of medicine was one issue, but the frail condition of starving bodies made recovery from even the slightest illness even more difficult. Staple supplies of flour and corn offered very little in terms of vitamins and

[339] Lass, "The Removal from Minnesota," 360-361.

[340] John P. Williamson to Thomas S. Williamson. June 9, 1863. Thomas Smith Williamson and Family Papers. Correspondence and Miscellaneous Papers. *Minnesota Historical Society*. Roll 1 (hereafter cited as *TSW*)

[341] John P. Williamson to Thomas. June 18, 1863. *TSW*

minerals. Clearly, Williamson rejected racialized assumptions about the natural hardiness of Native children. He believed that conditions at Crow Creek would have been impossible for any child to survive.

The physician who finally arrived at the Ho-Chunk reservation was ill suited for the position and put his own welfare above those of his patients. Dr. Wakefield seemed to carry a certain reputation with him as Williamson wrote to his father: "I am sorry to say [Agent] Galbraith has brought Dr. Wakefield with him…These Indians need a good doctor very much and the necessary supplies for sick folk."[342] Williamson's apprehensions about Wakefield were later confirmed when the doctor fled the reservation. According to Williamson, he "got so scared that he left last Sunday morning with some soldiers that were doing down to Ft. Randall. He gave as one excuse that there were no medicines here so that he could not do anything anyhow. I don't know whether he will be back or not. I think he is somewhat right about the danger, but while I have business here I don't feel like going away."[343] It is not clear what illness scared Wakefield, but it was likely contagious.

Williamson questioned the ability of the Ho-Chunk and Sioux to support themselves on the new reservation at Crow Creek.

> Where there is a man in the family with a gun they do very well, but there are only a few in that condition. About the only game is antelope and a very few deer. There are also a few beaver. There are no ducks or geese and no muskrats. The buffalo they say come in here sometimes but they would not do these Indians very much good as there are no horses and but few guns.[344]

[342] June 9, 1863. *TSW*
[343] June 18, 1863. *TSW*
[344] John P. Williamson to Thomas S. Williamson. June 9, 1863. *TSW*

Soldier Hansell verified this assessment of the land as largely barren. Hansell testified, though, that despite attempted hunting trips by the Winnabago people, they "were not successful."[345]

Food scarcity on the Crow Creek reservation fostered Ho-Chunk dependency on provision from the Federal Government. The move to the Crow Creek Reservation in the Dakota Territory increased the dependency of the Ho-Chunk on food provisions from the federal government since they had largely been stripped of their ability to feed their people in the relatively barren region. Doctor Samuel C. Hayes, assistant surgeon to the 6th regiment Iowa volunteer cavalry, testified in 1865 to a Congressional committee investigating the conditions of Crow Creek. In response to a question on "the manner in which the Ho-Chunk and Santee Indians were fed" over the winter of 1863 and 1864, Haynes admitted that the rations supplied to both groups were "not issued in sufficient quantities to subsist them." One of the most grievous displays of neglect, he revealed, occurred during the winter of 1863 when a large vat was constructed, "six feet square and six feet deep," too cook essentially a stew from which to feed them. Into the vat was thrown "beef, beef heads, entrails of the beeves, some beans, flour, and pork." Once the mixture was cooked, "all the Indians were ordered to come there with their pails and get it." Each man, woman, and child were fed from this vat, exceeding no more than eight ounces per person. Haynes admitted that the mixture gave off "a very offensive odor" and that it smelled "like decomposed meat." The agents continued distributing this mixture for a month despite protestations from the Ho-Chunk and Santee that "it made them sick."[346] The lack of food more generally left many with a difficult choice – sickness resulting from consumption of the beef mixture or starvation.

[345] Deposition of Joseph A. Hansell. Fort Randall, Dakota, September 2, 1865. "Condition of the Indian Tribes," 403.

[346] Deposition of Samuel C. Haynes. Fort Randall, Dakota. September 2, 1865. "Condition of the Indian Tribes," 401-402

In the fall of 1863, Baptise Lasalle, a chief among the Ho-Chunk, described the difficulties facing his people at the Crow Creek Reservation. "We are not afraid to die, but we do not wish to dies here," he pleaded. "This country is unhealthy. All our people are becoming sick." The most vulnerable included the children and the elderly whom Baptiste explained "are dying every day…[N]ever before have we had so many get sick and die without any bad disease, as since we have come here." What Baptiste described was not the outbreak of smallpox, or even cholera. Rather, people were dying because they lacked basic human necessities: food, clean water, and adequate shelter. Baptise warned, "If we stay here long, we think we will all die."

Starvation was the greatest threat to the Ho-Chunk during the time at Crow Creek, and as Doctor Haynes testified, was the primary cause of death. Haynes admitted that the Santee and Ho-Chunk "were constantly begging for something to eat." When he visited their lodges to attend to the sick, he admitted the difficulty of treating patients who were "destitute of food." Joseph A. Hansell, a soldier in company K, 6th Iowa cavalry, who was also stationed at Crow Creek between October 1863 and May 1864 testified to the desperation of the Ho-Chunk and Santee to feed themselves. He admitted, "I know of the Indians eating wolves that had been poisoned by the soldiers, and horses that had died. I also know of their eating mules that died with the glanders: and they picked up and ate the corn scattered about where we fed our horses." Some worked cutting wood at the agency, and received in exchange "provisions out of the warehouse."[347]

In desperation, many of the Ho-Chunk people fled to Nebraska in the south and took up residence on the lands the Omaha people; others decided to return to their ancestral homelands in

[347] Ibid, 402-403.

the North where they faced continual threats from federal officials who sought to remove them, under threat of force, to Nebraska. To sustain themselves, they cultivated a portion of the Omaha reservation and many began contracting as laborers on nearby farms in Nebraska and Iowa.[348] In 1865, as the Civil War came to end, the Ho-Chunk people negotiated a new and final treaty with the federal government that provided them with a small reserve of land, about one hundred and twenty-eight thousand acres, next to the Omaha. The Ho-Chunk people once again set to work healing the wounds inflicted on their community, just as they had after their removal in the 1830s. Now, however, there were even greater state restrictions on how to address these issues.

The health problems that continued for the Ho-Chunk people were initiated in the Civil War, but were sustained by the health costs associated with the creation of the reservation more broadly. Many other Native groups similarly faced health crisis and physicians, now working across most reservations, together with many Indian agents, did what they could to publicize these conditions into the early 1870s. One major problem was that the government tended to establish reservations in region's that white settlers found undesirable. James B. Thompson admitted as much to the Governor of the Colorado Territory in 1871. He explained that the location of a reservation near White River was "good country for Indians" because "there is no possibility of this portion of the Territory being inhabited by a permanent white population." He added, "I saw nothing which would invite occupation by even the most poverty-stricken and adventurous of our frontiersmen."[349]

[348] R. W. Furnas to Col. William M. Albin, Superintendent Indian Affairs, St. Joseph. September 10, 1864. Annual Report (1864), ARCIA, 352.

[349] James B. Thompson, Private Secretary, to Hon. Edward M. McCook, Governor and ex officio Superintendent Indian Affairs, Colorado Territory. September 1, 1870. Annual Report (1870), ARCIA, 170.

The reservation system also undercut the subsistence systems of many Native people. Dr. P. Moffat, the surgeon for the Hoopa Valley Reservation in California, explained in his annual report:

> This, their season of abundance, how spoiled now, and unproductive, by the presence and doings of the whites. They no longer sport on the banks of clear streams literally alive with salmon and other fish, but gaze sadly into the muddy waters, despoiled almonst of their finny prey by the impurities from the sluice-boxes of the miners at the head of the stream. In this consists one of the greatest calamities inflicted upon the Indians in recent years. Their salmon fishing is destroyed to a very great extent, and with it one of their chief means of subsistence. Those who saw the Klamath and Trinity rivers in early days say that during the summer months they ran as clear as crystal, and thronged with salmon from the sea; now they are muddy streams and almost deserted by this fish.

Moffat attributed most of these problems to white miners who had polluted the streams and eliminated the main food supply of fish. Moffat explained that the healthy diets of fish, vegetables, and wild berries had largely been replaced by rations of beef and flour. Moffat recognized that the reduction of fish and the increased reliance on beef and flour was not beneficial to the health of the tribe. He wrote, "I feel fully satisfied, from my observations and experiences with these Indians, that their lives are preserved from year to year largely by the large quantities of fish oil they make use of as food.

Like other agents and physicians, Moffatt assumed that the "inherent constitutions" of Native peoples contributed to their dire situation. He and others assumed Native people were a distinct race with bodily reactions to food and other conditions that differed from the reactions of white people. So, for example, Moffett believed that fish counteracted the diseased state that "Indians, every one of them so far, inherit." If fish supplies were not replenished, Moffatt hypothesized that the "Indians, with the constitutions these possess, would quickly disappear."[350]

[350] Dr. P. Moffat to Hon. Chas. Maltey, Superintendent of Indian Affairs, California. July 1, 1865. Annual Report (1865), ARCIA, 116-118.

Despite what they assumed to be the distinctive physical vulnerability of Native peoples, many physicians and agents argued that the federal government had a moral obligation to address the health crisis. Some of them insisted that attention to Indian health would also further the civilizing project. In 1871, Henry Breiner, the agent to the Seminoles, argued that medical care not only helped address cases of sickness "that must have otherwise proved fatal;" they also helped "show to and convince the Indians of the advantages and benefits resulting to many from the arts and sciences of civilization."[351] In the view of Breiner, medical was "a duty which enlightened nations owe to the benighted and ignorant by Divine injunction." Indian agent Charles LaFollett in Oregon and sub-Indian agent G.A. Henry in Washington both argued that greater provisions for medical care and attendance would "aid in the work of civilizing and Christianizing the Indians."[352]

Still others saw medical services as offering direct benefits to the state. The Indian agent at the Paiute reservation argued that better health care facilities and services would help Native compliance with reservation policies. One of the most frequent complaints by federal agents was the refusal of Native groups to stay within the reservation boundaries and settle into permanent homes near the central agency. It was common for Native groups to continue seasonal migrations and activities, particularly as they related to hunting. The Indian agent believed that better medical services would encourage them to stay put. As he wrote, "the erection of a good hospital-building will not only do much to lead other Indians to this reservation who have agreed to come, but make them satisfied to remain after getting here." [353]

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[351] Henry Breiner to E.S. Parker. September 1, 1871. Seminole Agency Report, Annual Report (1871), ARCIA, 586.

[352] Charles La Follet to A.B. Meachem, Superintendent of Indian Affairs for Oregon, Annual Report (1870), ARCIA, 64; G. A. Henry to Gen. R. H. Milroy, Superintendent of Indian Affairs for Washington Territory, Annual Report (1873), ARCIA, 312.

[353] November 30, 1873. Annual Report (1873), ARCIA, 327-328.

Dr. Gaeb, who worked in Nevada among the Pauite as an agency physician, argued that medical services could also help undercut the influence of tribal leaders, including "medicine men," widely regarded as impediments to civilizing project. Gaeb believed that his work among the Paiute during an outbreak of malaria provided evidence of such success. He ran a tight ship, refusing to provide medical care on an outpatient basis because he believed patients failed to follow medical instructions. Instead, he established a highly regulated system. Patients could not take medicines home with them. Gaeb required them to "report to the surgeon's quarters at a specified time, and receive the medicine directly from the acting hospital steward." Patients were also provided "daily rations of flour, tea, &c." Gaeb interpreted the actions of people seeking his care as proof that they no longer valued their own traditional healers. As he wrote in his annual report, "Many of their superstitious ideas regarding medical treatment and the power of medicine are being eradicated as they see the results of medical skill, and the proper care of those that are sick."[354]

Superintendents J.W. Powell and G. W. Ingalls used Dr. Geib's work on the Pai-Ute reservation to recommend the creation of an "efficient medical department" on each reservation. Tasked with ascertaining how to better manage reservations in the American Southwest, Powell and Ingalls concluded that there was utility in expanding federal health care services. They argued that each reservation could benefit from an "efficient medical department" as agents noted that much of the disease and sickness experienced on their reservations could be addressed with increased medical attention. Powell and Ingalls, in many ways repeating the arguments made by Dr. Gaeb, suggested that more efficient medical services would lessen the influence of traditional healers. Powell and Ingalls that these figures, whom they referred to as "magician[s]"

[354] Ibid, 327-328.

or "medicine-m[e]n," wielded enormous power and influence within their respective communities. "[S]uch influence," they argued, "is always bad." In particular, Powel and Ingalls complained that these figures were undermining "civilizing" efforts. Their solution was simple. Place an "an intelligent physician" to work on each reservation to help demonstrate the superiority of western medicine and the deceptive practices of these "medicine men."[355]

Building a Medical and Educational Division

All of this evidence provided a strong case for Edward P. Smith to make changes to the decentralized, loosely monitored federal Indian health care system after President Grant appointed him Indian Commissioner in 1873. Central to Smith's "reconstruction" of federal Indian health care services and his formation of a Medical and Educational Division to address the sickness and suffering across reservations, were his Christian background and his missionary experiences in the post-Civil War South. Smith was born in 1827 in South Britain, Connecticut and educated at both Dartmouth and Yale. He became a pastor in the Congregational Church and ministered to congregations in the Northeast, including the Congregational Church at Pepperell, Massachusetts. During the Civil War, he dedicated his efforts to the United States Christian Commission, an organization of civilian volunteers who provided medical resources and religious support to Union soldiers. After the war, he continued his efforts as a field agent for the American Missionary Association (AMA), an organization which began operations in the South as early as 1861. These efforts included the distribution of "spelling books" to escaped slaves in the war's early years and later expanded to the establishment of day schools for

[355] Ibid, 64.

freedpeople. Members of the AMA believed a Christian education was necessary for the "uplift" and "civilization" of the South's black population. Smith, in particular, played a prominent role in the organization's efforts to support black higher education. Between 1866 and 1869, the AMA chartered seven colleges, including Howard University and Fisk University across the South.[356] While these colleges provided educational opportunities to black southerners, they were run and primarily staffed with white northern teachers and administrators who "believed their ways superior to those of southerners." The strict rules and regulations of these colleges, which often included boarding schools, were "to infuse students with a reputed superior northern Christian culture."[357]

Smith's work with the AMA brought him into frequent contact with agents of the Freedmen's Bureau. In 1865, Congress created the Freedmen's Bureau to provide emergency assistance to the millions of former slaves across the South and assist them in their transition from slavery to wage labor. While much of the Bureau's work centered on overseeing labor contracts, this assistance also included supplying basic provisions, including clothing and food, and government provided medical care. Congress did not originally appropriate funds for educational purposes, but officials within the Bureau found ways "to assist educational societies," including the AMA. Bureau agents helped protect white teachers who faced hostility from northern whites in their efforts to educate freedmen in the South. The Bureau also helped lessen expenses of the AMA by providing transportation for teachers from the North to the South, supplying schools with food supplies, and allowing teachers to buy government provided rations at lower costs. These efforts also included financial support in the construction of school

[356] Joe M. Richardson, *Christian Reconstruction: The American Missionary Association and Southern Blacks, 1861-1890* (Athens: The University of Georgia Press, 1986), 3-14, 123-140.

[357] Ibid, 138. Richardson explains that while "teachers were often paternalistic and sometimes arrogant in their assumptions of cultural superiority…their intent was egalitarian."

buildings. In fact, it has been noted that "almost every association college, normal, and secondary school was partially built with Bureau funds."[358] Smith's work alongside Bureau officials demonstrated the positive impact of Republican led state-building activities in supporting "civilizing" efforts of missionary societies such as the AMA.

Smith's work with the AMA was foundational to his appointment by President Grant as Indian Commissioner. In fact, Grant received Smith's name after he asked leaders within the association "to recommend a man suitable to carry out his peace policy."[359] Grant's peace policy involved a "turn to religious groups and religion-minded men for the formulation and administration of Indian policy."[360] Smith embodied the "religion-minded" man Grant hoped could help induce Native people to remain on reservations and commit to their "civilization" and "Christianization." Smith made clear his commitment to Grant's policy in his annual report in 1873. He wrote, "no effort for lifting the poor and degraded can succeed which is not guided by the enthusiasm which comes from faith."[361]

Creating the Medical and Educational Division in 1873 was one way that Smith advanced Grant's peace policy. The sickness and suffering documented across reservations no doubt spurred Smith's Christian sympathy. Just as reform-minded officials in the 1830s argued the state held a paternalistic responsibility to provide medical support, so too did Smith most likely view medical aid as a matter of humanitarian outreach. But arguments made by Indian officials that tied medical aid to state interests were also compelling. A central aspect of Grant's peace policy centered on forcing Native groups within the boundaries of the reservation system. The argument advanced by Superintendents Powell and Ingalls in 1873, that medical aid could

[358] Ibid, 82-83.
[359] "Rev. Edward P. Smith" *The New York Times* [August 16, 1876]
[360] Prucha, *The Great Father,* 153.
[361] Annual Report (1873), ARCIA, 10.

support efforts to compel Native groups to remain on reservations, demonstrated to Smith the potential for medical aid to advance Grant's peace policy.

Placing medical care and education together demonstrates that Smith saw the two as mutually constitutive. In his first annual report, Smith made clear his commitment to educational outreach as foundational to the larger "civilizing" mission of the Indian Office. He wrote, "any plan for civilization which does not provide for training the young…is short sighted and expensive." His faith in education was ambitious. He argued, "four or five years of this appliance of civilization cures one-half of the barbarism of the Indian tribe permanently." If curing "barbarism" was Smith's goal, then "medicine men" were most likely an intended target for elimination. Many "medicine men," in fact, were noted by agents as interfering in educational efforts on reservations. After all, it was common for training and initiation into a tribe's medicine society to begin at a young age. Smith, it appears, envisioned medical aid as an integral component in reducing the influence of these men and their deleterious impact on educational outreach among Native youth.

To head this newly created division, Smith appointed Dr. Josiah Curtis as its first director. Dr. Curtis brought with him an extensive background working on public health issues in the Northeast; but his specialty was in statistical data gathering and analysis. A member of the American Medical Association, Dr. Curtis joined the Committee on Public Hygiene at the association's first regular meeting in 1848 and set to work collecting information on matters relating to hygiene in Massachusetts. He used such information in an effort to gauge the impact of legislation on matters related to health. For example, he drew a correlation between the rise of smallpox deaths and the repeal of a law requiring patients suffering from the disease to be removed to a hospital. In the process he made a case for the value of the medical professionals

in addressing issues related to disease.[362] Dr. Curtis' work in public health continued in the Northeast in the 1850s. After the completion of his work with the Committee on Public Hygiene, he continued work on statistical data collection for the state of Massachusetts, assessing the results of sanitary surveys, and the federal census in 1860. The use of statistical data to elevate the role of the AMA and justify not only its existence, but also expand its role within a state like Massachusetts, was work that Commissioner Smith most likely saw as particularly fruitful for the newly created Medical and Educational Division,

Dr. Curtis' work built upon French and British developments in statistical analysis which involved the practice of "amassing and collating facts and attempting to discern patterns among them." In medicine, data was collected and interpreted to investigate "non-specific social and environmental influences on health and disease."[363] Particularly influential to the AMA's success and Curtis' career was the work of Dr. William Farr, who served as the superintendent of statistics at the General Register Office of England and Wales (1839-1879). In the late 1830s, Farr tabulated "sickness tables" which tracked the course of epidemic diseases. His work, the first of its kind, was published in the *British Annals of Medicine* in 1837 and demonstrated the utility in tracking not only those who died during epidemics, but also those who recovered. Farr sought to extract "laws" regulating disease, which in many ways fueled the work of the AMA and Curtis who sought to replicate this novel approach to vital statistics in Massachusetts in the 1840s.[364]

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[362] Josiah Curtis, M.D. "Brief Remarks on the Hygiene of Massachusetts" Transactions of the American Medical Association, vol II. Philadelphia: T. K. and P.G. Collins, 1849.; Barbara Gutmann Rosebkrantz. *Public Health and the State: Changing Views in Massachusetts, 1842-1936* (Cambridge: Harvard University Press, 1972), 26-27.

[363] Michael Donnelly. "William Farr and Quantification in Nineteenth-Century English Public Health." *Body Counts: Medical Quantification in Historical and Sociological Perspectives*. Ed. Gerard Jorland, Annick Opinle, and George Weisz. (McGill-Queen's University, 2005), 252-253.

[364] Ibid, 253-255.

Curtis brought his skills in health-related data collection and interpretation to his new position in the Indian Bureau. He immediately set to work gathering quantitative and qualitative information about the state of medical care and general health conditions across reservations. He arranged for circulars to be distributed to physicians asking them to collect information about the types of diseases most prevalent within reservation communities, birth rates, death rates, and the number of patients receiving care. In 1873, E. J. DeBell, physician to the Ho-Chunk in Nebraska, sent his responses to Commissioner Smith's circular. First, he provided a detailed accounting of the number and causes of each death on the reservation. Cholera morbis – 2; Inflammation of the bowels – 1; Consumption – 3; Inflammation of the lungs – 2; Remmittent fever – 3. Homicide – 1; Suicide – 1; Died from Unknown Causes – 10. In total, DeBell explained the deaths of thirty-four individuals on the reservation. Next, he provided the number of births: twenty-one male and fourteen female babies born. Lastly, DeBell made an argument for his work on the reservation. He detailed the number of patients visited and prescribed medications, both "at their habitations" and "at the dispensary." The number of patients treated at their place of residence from November to August totaled 608, while the number of patients treated at the dispensary totaled 413. The agent listed the total population on the reservation at 1,445 persons which meant a participation rate of seventy percent. Perhaps DeBell was worried about his continued employment in the position of agency physician or the future of agency physicians more generally because he added, "I would also represent that the Indians are steadily gaining confidence in the Agency Physician's treatment – and that - they profit by the treatment." [365]

[365] E.J. DeBell, Physician, to the Honorable Commissioner of Indian Affairs, Washington, D. C. September 18, 1873. NARA M234 Roll 946

The Indian Bureau published the physician's data first as brief statements in 1874 and shortly thereafter as tabular reports beginning in 1876. In 1875, the information was presented as a separate report titled "Information with Historical and Statistical Statements Relative to the Different Tribes." This was in accompaniment to, and not a replacement for, the agency reports that were written and published by the agents, subagents, and physicians working on reservations. The 1875 report had very few numbers and was presented as short descriptive paragraphs on each tribe. The only consistency in these reports was the publication of population information. In 1876, this information was presented in tabular form published in a separate report titled "Table of Statistics Showing Population, Schools, Churches, and General Conditions of Indians." The medical information included three categories: the number who received medical care during the year, the number of births, and the number of deaths. The information across reservations was far from accurate and the information collected incomplete. But a recapitulation of the information was provided at the end of the table. Out of a population of 266,151 Native peoples living within the United States and 40,639 "mixed-bloods" accounted for, the "number of Indians who have received medical treatment during the year" equaled 37,252. The number of births, while missing for many tribes, was presented as 2,401 and the number of deaths 2,215. An asterisk noted that these totals excluded the so-called Five Civilized tribes comprised of the Choctaw, Cherokee, Chickasaw, Creek, and Seminoles.[366] In 1877, the same information was provided in the annual report but with greater participation across reservations. Total population of Native peoples counted at 250,889, "mixed bloods" accounting for 27,749. The number of births was counted at 3,442, the number of deaths at 2,781, and the

[366] Annual Report (1876), ARCIA, 206-223.

number receiving medical treatment at 48,734.[367] The data presented was vague and provided very little useful information from which the general health of Native peoples across the reservation system could be assessed.

In 1877, administration officials attempted to draw larger conclusions from the data collected and published in 1874, 1875 and 1876. In the new summary, officials not only questioned the widespread trope of the "vanishing Indian" but also reiterated the importance of medical treatment as a corollary to the civilizing process:

> If, as is generally believed, the Indians are a vanishing race, doomed to disappear at a not remote period, because of their contact with civilization, or for any other reason, then the efforts in behalf of their civilization will assume, in most minds, a sentimental aspect, and will hardly be considered in their true relation as regards their practical importance. But, on the contrary, if it is shown to be true that the Indians, instead of being doomed by circumstances to extinction within a limited period are, as a rule, not decreasing in numbers, and are, in all probability, destined to form a permanent factor, an enduring element of our population, the necessity of their civilization will be at once recognized, and all efforts in that direction will be treated as their importance demands.[368]

John Eaton, a bureaucrat within Department of Interior, while careful not to draw definitive conclusions from such a small data set, hinted that the dominant idea of the vanishing Indian, of a population "destined to decline and finally disappear," needed to be reconsidered and "probably abandoned altogether."[369] Health issues might be present across reservations, but a relatively stable population meant that Native peoples needed to be considered a permanent presence within American society. This assessment would necessitate greater federal intervention into civilizing and assimilating this permanent population of people.

[367] Annual Report (1877), ARCIA, 303. Medical attendance not provided in 1878 annual report; Total population: 250, 864, births 2,941, and deaths 2,219. Annual Report (1878), ARCIA, 296.

[368] "Are the Indians Dying Out?" Annual Report (1877), ARCIA, 494.

[369] Ibid, 520.

While some reports indicate that the Medical and Educational Division was dismantled in 1877, the date usually noted as the formal end of Reconstruction in the South, the work of the division continued. The continued gathering and dissemination of statistics related to Native health serves as a case in point. In 1879, administrators at the Bureau published more detailed statistics on Native disease and ill-health.[370] Total population numbers (252,897), births (2,352), and deaths (2,025) were still provided.[371] A separate report titled "Table showing prevailing diseases among Indians, number of cases of sickness treated, &c." Out of sixty-seven agencies listed in the West, fifty-seven agency physicians provided information on the prevalent diseases treated on their reservations. The diseases were classified into seven categories: zymotic diseases (fevers and contagious diseases such as smallpox, typhoid fever, whooping cough), syphilis and gonorrhea, constitutional diseases (diseases of the nervous system, eyes, ears, circulation, respiration, digestion, and urinary), tuberculosis, parasitic, joints and bones, and integumens (skin). Casualties were also listed, although it was not specified what caused these deaths. The data presented in 1879 presented a shocking snapshot of sickness and disease across nearly all reservations, with the number of cases of disease and sickness far outnumbering the total population of the tribe. For example, the Cheyenne and Arapaho in Indian Territory, with a total population of 5,496 persons, listed 10,273 diagnosed cases of disease and sickness. 5,576 were listed as zymotic diseases, 194 cases of syphilis and gonorrhea identified, 4,494 constitutional diseases treated, 1 person treated for sickness related to the joints and bones, and 8

[370] It has been suggested that the Medical and Educational Division was shut down at the end of Reconstruction in 1877. However, from internal correspondence and publications in the Annual Report, it is clear that the activities of this division continued into the 1880s.

[371] Annual Report (1879), ARCIA, 244.

cases of integumentary disease.[372] This means that many persons were diagnosed with multiple cases of sickness and disease during the year.

The turn to quantifying disease drew upon emergent imperial trends in medicine and the work of the Freedmen's Bureau in the South. In each of these instances, the practice of collecting and disseminating statistical information related to sickness and disease largely worked to "impos[e] the power of the state on the body."[373] In the post-war South, physicians working in the Medical Division of the Freemdmen's Bureau "relied on a system of reporting that simply calculated the number of patients that were infected, the number under treatment, and then the number that died." These "statistical portrait[s]" of disease provided "empirical proof" to Bureau officials that freedpeople were predisposed to some diseases, including smallpox.[374] The quantification of diseases within the Indian Office worked in a similar fashion. The reports helped affirm officials' racialized presumptions about Native bodies. They also lent medical authority to agency physicians (and by extension the medical profession), validated their necessity as state agents, and lent justification for an increasingly active custodial role for the federal government within reservation affairs.

Commissioner Smith also instituted a system of field inspections to gather information about conditions at each reservation, the qualifications of resident physicians, and the behaviors and practices of the reservation population. On August 22, 1873, Field Inspector E. C. Kemble submitted his report to Commissioner Smith following his inspection of the Umatilla Agency in Oregon. He reported to Smith: the Business Condition, the General Condition of the Indians, Use of the Lands of the Reservation, Moral and Sanitary Conditions, Missions and Schools,

[372] Annual Report (1879), 263.
[373] Gerard Jorland and George Weisz, *Body Counts*, 8.
[374] Downs, *Sick from Freedom*, 101-102.

Adaptation of Means at the Agents Command, Interviews with the Indians, and Statistics of Labor and Production. Most of his report was an assessment on the behaviors and practices of those belonging to the reservation. He reported that "these Indians possess a Reservation of 550,000 acres of land, some it the very best in the state, and are reputed to be worth in individual property (principally cattle and horses) from $160,000 to $200,000." Their overall condition, he lamented, "is far from encouraging," and blamed the situation on their persistent "nomadic and vagrant habits." The Indians, he observed, "show little disposition to settle upon or cultivate their lands." He warned that continued behaviors such as these, monitored by individuals like him, would not go unpunished. Kemble assured Commissioner Smith that he warned "the leading chiefs and men of the three tribes… that unless they were diligent in the use of the means and opportunities afforded for their instruction and for the civilization of their people they could not hope to hold the land in the future."[375] These field inspections were a means of federal oversight of reservation practices, but also importantly a means to monitor the reservation population.

Kemble was also directed to monitor the activities of the agency physician, including his qualifications and the type of diseases he treated most frequently. He gave the physician a circular with fourteen questions and provide the physician's responses in accompaniment to his inspection report. The questions generally fell into three categories. The first included questions relating to qualifications and his prior experiences practicing medicine. The second group of questions related to personal beliefs, including religious affiliation and church membership. Clearly the Indian Office wanted to physicians to be aware that they were also instruments of the state; they were tasked with delivering medical care and assisting in the larger civilizing project

[375] August 22, 1873. Inspector File No. 554. M1070, Roll 33, Target 2, Oregon Superintendency. Regional National Archives, Riverside.

of the Indian Bureau. The last group of questions related to the behaviors, habits, and illnesses of the reservation population. The questionnaire included questions on the types of diseases most commonly treated and where those on the reservation sought care from their own medicine men or the physician.[376] Largely missing from the questionnaire were any positive questions related to health on the reservation. By only focusing on disease and sickness, the questionnaire supported and furthered the common narrative that reservations and those living within the boundaries of the reservation were naturally diseased. This seemingly confirmed emerging scientific thoughts that imagined Native bodies as inherently weak and prone to disease.

Physicians and field inspectors provided Commissioner Smith and his predecessors with a means to monitor the nation's Native population. Their practices and questions were intrinsically invasive as they related to matters of the body. Physicians and field inspectors were acting as the eyes and ears of the state, providing intimate access to matters related to health, healing, sickness, and disease. They helped to create racialized accounts of Native disease and sickness. In turn, they gave power and authority to physicians and field inspectors, and seemingly compelled state officials to adopt more invasive and intrusive policies to regulate, monitor, and control the behaviors and practices of Native peoples.

Standardization of medical practice accompanied the bureaucratization of the Bureau's Indian healthcare system. By the late 1870s, physicians were ordering supplies by filling out 3-page standardized forms that listed medicines and medical supplies from which the doctor could choose. They no longer placed their orders with improvised hand-written notes. In 1878, the physician overseeing the medical care of the Ho-Chunk at the Nebraska Agency received sixteen packages from New York City, that included: sixty four 4-oz bottles of carbolic acid,

[376] August 22, 1873. Inspector File No. 554. M1070, Roll 33, Target 2, Oregon Superintendency. Regional National Archives, Riverside.

sixty four 8-oz bottles of citric acid, eight 4-oz bottles of nitric acid, thirty 32-oz bottles of alcohol, ninety six 8-oz bottles of ammonia, three hundred twenty 8-oz bottles of camphor, one hundred ninety two 1-lb tins of ether (for anesthesia), fifty yards of unbleached muslin, fifty yards of adhesive plaster, an assortment of syringes and vials, twenty four 8-oz pots of mercury pills, five hundred bottles of opium pills, and three thousand bottles of opium and camphor pills.[377] These orders reveal a more streamlined process for distributing and accounting for medical supplies.

Centralization and bureaucratization extended to the hiring of agency physicians. In 1868, President Grant sought to expunge corruption within the Indian Office by shifting many responsibilities from Indian agents to Christian missionaries. Grant's "Peace Policy" directly impacted the hiring and assignment of reservation physicians. When Dr. Lowry resigned his position at the Ho-Chunk Agency in 1871, U.S. Indian Agent Howard White contacted the Committee of New York Yearly Meeting of Friends, a religious society of Quakers, to request a replacement. The Committee offered the position to Dr. Bartheson, who promptly declined. Faced with increasing medical need and demand for medical treatment from the Ho-Chunk people, White offered the position to E. J. Debell. Agent White later admitted that he made this rash decision "without knowing" DeBell's past and "without asking for any documentary evidence of [his medical] degree." DeBell, White later recounted, "had recently arrived from the East, was about to open an office in the neighboring town of Covington and was advertising himself in the local paper as a physician and surgeon." Agent White resigned his position in the

[377] Receipt for Medical Supplies for Winnebago Agency. Received by Howard White. Letters Received by the Office of Indian Affairs, Nebraska Agencies 1876-1880. NARA, RG 75, M234, Roll 522

fall of 1873 at the Ho-Chunk Agency and admitted, "I became convinced that E. J. DeBell was not altogether what he professed to be."[378]

Much of the dissatisfaction, White admitted, had been brought to him by Ho-Chunk leaders during council. They proposed that DeBell be replaced by"one or more nation doctors in whom they had some confidence." The employment of a doctor from within the community to serve as the agency physician would have served the interests of the Ho-Chunk on multiple levels. This would have placed all matters related to health and sickness within the care and power of the Ho-Chunk people. Second, this was also an economic opportunity. While many agency physicians and agents lamented over the decreasing annual salaries for the position of physician, there were very limited means for economic opportunity for Native peoples within the reservation. This would have been an enormous sum of money that could have been used at the discretion of the community, not the federal agent.

The decision fell to White's successor, Agent Bradley, who did not make any immediate changes to DeBell's employment status within the Agency. It was not until Agent White returned to his position as US. Indian Agent at the Ho-Chunk Agency in October of 1875 that he finally removed DeBell from his position before the end of his first six months at the reservation. After leaving his post, rather than offering his services as physician within the community, he took a position as editor at the *North Nebraska Eagle*. In his place, Agent Bradley hired Dr. Lamb, a former physician at the Pawnee Agency who had as physician there by the Committee of Friends.

[378] Howard White, US Indian Agent, to Commissioner of Indian Affairs. June 8, 1877 NARA RG 75, M234, Roll522

By 1877, the Committee of Friends no longer had authority over the hiring of the agency physician; instead the decision was in the hands of the Indian Bureau. E.J. DeBell requested reappointment as physician with the Indian Bureau citing his ability to speak the Ho-Chunk language, his attention to matters related to the "sanitary condition of the Indians," his honest, integrity, and the satisfaction of the agency population under his care. He also listed support from several citizens of Dakota County, Nebraska who could attest to his character.[379] Indian Commissioner John Q. Smith responded to this application by requesting information on DeBell's previous work at the Ho-Chunk Agency during the period from 1871 to 1875. Agent White's scathing response countered much of what DeBell claimed and former Agent Taylor Bradley's letter confirmed Agent White's assessment. In a letter forwarded to the Commissioner of Indian Affairs, Bradley declared that E. J. DeBell was "unfit for an employee among the Indians, as Physician or anything else." He characterized DeBell as a dishonest "infidel" and "very unpopular with the tribe." Moreover, DeBell "often absented himself from the Agency without the knowledge of the Agent for the purpose of hunting or otherwise when his services were actually needed at his post."[380] By 1878, C. R. Sleppens had replaced DeBell as agency physician.

It would be a mistake to suggest that Agent White's actions with respect to DeBell signaled respect for the outlook of the Ho-Chunk people. In 1870, he oversaw the replacement of tribal leadership in the Nebraska Agency and the removal of "all members of the band called Medicine Men" from leadership positions within the tribe. He characterized such men as "nearly all devoted to their superstitious rites, opposed to civilization, and utterly inefficient for any

[379] Howard White, US Indian Agent, to Taylor Bradley, Late U.S. Indian Agent for the Winnebago Indians. May 28, 1877. NARA, RG 75, M234, Roll 522

[380] Taylor Bradley to Howard White. May 31, 1877. NARA, RG 75, M234, Roll 522

useful purpose." More troubling yet, according to Agent White, was their resistance to an outside examination (or more aptly prosecution) of "charges made against some members of the tribe accused of a murder." Their assertions of sovereignty, to decide tribal matters on their own, was the larger point of contention. White's aggressive stance with respect to the medicine men won support and encouragement from the central administration of the Bureau.[381]

While attempts were made to hire quality physicians to treat Native peoples on reservations, some actions taken by the Indian Office made this more difficult. This included the reduction of salaries of agency physicians. In 1874, the Indian Bureau reduced the salaries of reservation physicians from $1000 to $850.[382] The federal government, it seems, wanted to increase the quality of their physicians while simultaneously cutting costs.

"civilization and savagery cannot dwell together": Creating Courts of Indian Offenses

In 1883, the Secretary of the Interior, Henry Teller, attempted to foreclose opportunities for Native peoples to navigate medical worlds largely on their own terms. "Civilization and savagery," he argued, "cannot dwell together; the Indian cannot maintain himself in a savage or semi-civilized state in competition with his white neighbor, and must adopt the 'white man's ways' or be swept away by the vices of savage life, intensified by contact with civilization." He believed that the current "status quo" could not be maintained and feared that the segregation of Native people was not possible, nor was it in the nation's best interest. He wrote, "Humanity revolts at the idea of his destruction, yet it is far better that he should disappear from the face of

[381] September 20, 1970. Annual Report (1870), ARCIA, 228

[382] Statement of Reduction of Salaries. "Letters Received by the Office of Indian Affairs, 1824-1880." Winnebago Agency, NARA, RG 75, M234, Roll 945.

the earth than that he should remain in his savage state to contaminate and curse those with whom he must necessarily come in contact in the future."[383] Teller asserted that he did not believe that Native peoples were destined to disappear, nor that they were incapable of this reformation. While proven false with ten years of accumulated data by the Medical Division on birth rates and death rates on reservations, the narrative of the vanishing was continuously deployed by federal officials when it appeared advantageous. It helped deflect responsibility for health conditions to the behaviors, practices, and inherent constitutions of Native peoples themselves, and framed any government intervention as benevolent and generous. Here it was used to support greater government intervention as absolutely necessary to aid the process of creating civilized, self-supporting communities.

This transformation, Teller believed, could only be attained through legal activism. He submitted his recommendation for the creation of courts of Indian offenses to provide a mechanism through which agencies could compel Native peoples to become civilized. Particularly destructive, he warned, was the continued presence and influence of "non-progressive, degraded Indians" whom he argued were "allowed to exhibit before the young and susceptible children all the debauchery, diabolism, and savagery of the worst state of the Indian race."[384] In a letter written to the Commissioner of Indian Affairs, Secretary Teller made clear that the courts should have jurisdiction over an array of ceremonial practices, including the sun-dance, marital relations between Native men and women, gender relations, and matters related to Native health and healing. Especially disturbing to the Secretary was the privileged role of "medicine men" on reservations, whom he argued are "active in preventing the attendance of the

[383] Annual Report of the Secretary of the Interior. United States. Department of the Interior. Washingto: G.P.O, 1882/3.

[384] Ibid, 10-11.

children at the public schools." He admitted, "I am not ignorant of the difficulties that will be encountered in this effort." Referring to growing factionalism within tribal communities, he wrote: "I believe in all the tribes there will be found many Indians who will aid the Government in its efforts to abolish rites and customs so injurious to the Indians and so contrary to the civilization that they earnestly desire."[385] Civilizing efforts had produced fractures within many communities. The Secretary sought to exploit these fractures and turn one group against the other to more effectively route out cultural traditions antithetical to white, middle-class norms and practices. This included bringing to an end the continued reliance and prominence of traditional healers and their role as important religious, political and medical figures within their communities.

Physicians, it seemed, had been ineffective in severing these bonds on their own. In-roads had been made, but the power of the state was needed to force compliance. The creation of courts and the targeting of "medicine men" for elimination reveal the heightened obstacles for Native peoples to address matters of health, healing, and the body, largely on their own terms by the latter decades of the nineteenth century. While an examination of the Ho-Chunk peoples in the 1870s reveals that many of these efforts began on individual reservations prior to this declaration by the Secretary Teller, by 1883, this was now the official policy of the Indian Office.

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[385] Ibid, 12.

The bureaucratization of federal Indian health care services that took place during the period of Reconstruction reveals how state power and governance expanded westward and led to significant changes within the administration of Indian Affairs as it related to federal health services. This newly created Medical and Educational Division in 1873 did not lead to substantive improvements to the delivery of medical care to Native peoples. Rather, it became a bureaucratic arm that enabled federal officials to enact policies to serve the interests of an expanding and increasingly aggressive state in the post-Civil War period. Federal officials used the Medical and Educational Division and its employees to support state efforts to assimilate Native peoples and replace religious, cultural, and social practices with that of white America. Physicians emerged as important state intermediaries in furthering this national project. By constructing a racialized account of Native American disease, they provided the state with a rationale for enacting more invasive state policies and for assuming a more active custodial role. While this was a temporary bureaucratic structure, the practices established by the division continued and shaped reservation health care until the 1930s.

By 1883, however, federal officials saw physicians as incapable of accomplishing these goals on their own and created courts of Indian offenses to assist assimilation efforts across reservations. This marked a dramatic escalation to federal efforts to replace Native cultural and religious practices with that of white America. Federal officials identified "medicine men" as impediments to civilizing efforts and saw their continued influence and privileged role within Native American communities as threatening, particularly when it came to educating Native children. These efforts signaled a dramatic shift in the relationship between Native peoples and the state. Native peoples who saw federal health care services as beneficial to their people in the

1830s, 1840s, and 1850s could not have anticipated how bodily control would become a part of America's colonial project by the late nineteenth century.

Conclusion

Witnessing the Medicine Dance: The Persistence of Ho-Chunk Medicine Ways

In 1908, Paul Radin made several trips to Winnebago, Nebraska and River Falls, Wisconsin to conduct fieldwork among the Ho-Chunk people as part of his doctoral studies in Anthropology at Columbia University. Between 1908 and 1913, Radin completed what he described "as intensive an investigation as the time spent allowed."[386] Radin found willing participants among the Ho-Chunk in both Nebraska and Wisconsin. Radin saw these participants as necessary to capture "an inside view of an Indian's thoughts."[387] He conducted interviews with individual tribal members and recorded songs, rituals, and ceremonies, including the Medicine Dance. His fieldwork provided him enough research material to complete his doctoral thesis, "The Ritual and Significance of the Winnebago Medicine Dance" in 1911,[388] and publish several other works about the Ho-Chunk people, including *The Winnebago Tribe* in 1923 and *The Autobiography of a Winnebago Indian* in 1920. While Radin assumed he was recording the social, cultural, and religious customs and practices of a "vanishing," people, Radin's works reveal the strength and resilience of the Ho-Chunk people and the continuation of their medicine ways and practices.

Radin's publications stand testament to the persistence of Ho-Chunk medicine ways and the failure of state policies to sever ties between Native peoples and their "medicine men" by the early twentieth century. Of particular significance is Radin's publication on the continued traditions associated with the Medicine Dance, the Ho-Chunk's secret society. This is especially noteworthy given the actions of the Ho-Chunk's Indian agent who expelled all members of the

[386] Radin, *The Winnebago Tribe*, xv.
[387] Radin, "Personal Reminiscences of a Winnebago Indian," 293.
[388] Radin's thesis was published in the *Journal of American folk-lore* in 1911.

Medicine Dance from the tribe's political leadership in the 1870s. Despite this intervention into the internal political affairs of the tribe, the agent failed to eliminate the privileged position of these "medicine men" and their vital role to the spiritual and physical health of the Ho-Chunk people. Radin noted the significance of the society when he acknowledged that "the Winnebago suppose it to be a repetition of a ceremony originally instituted by the Rabbit, when he initiated the first man into its secrets."[389] The continuation of these ceremonial traditions, an in particular the continued initiation of new members into this secret religious society, marked one way that Ho-Chunk medicine ways endured U.S. assimilation policies in the latter decades of the nineteenth century.

During his ethnographic fieldwork, Radin interviewed Ho-Chunk members who revealed that the Ho-Chunk people still relied upon a multitude of Native remedies to treat sickness and disease. This included the continued use of an astringent medicine, comprised of a mixture of "clear" and "plant" medicines, to treat swelling and illness after childbirth. Healers also used a "bladder medicine," derived from "the roots of a certain weed," to treat urinary incontinence. For burns, the Ho-Chunk still used "the leaves of a certain weed" that were dried, masticated, and applied directly to the skin.[390] Collectively, these activities and practices demonstrate the endurance of Ho-Chunk medicine ways.

Yet survival and persistence did not come without costs. Initiation into the Medicine Dance did not privilege members to immediate knowledge of the songs, rituals, and ceremonies. New members entered into a system of apprenticeship and earned access to greater degrees of membership over time. At some point, the passing of knowledge from one generation of healers to the next was disrupted. According to one informant, this impacted knowledge associated with

[389] Radin, "The Ritual and Significance of the Winnebago Medicine Dance," 149.
[390] Radin, *The Winnebago Tribe*, 217-219.

a particular type of medicines the interviewer labeled as "good medicines." These medicines were more powerful in nature. They could make a man "invulnerable" during war and provide "those who are not accustomed to hunting" with the ability to kill game in times of hunger. The interviewer admitted that "the last man who had [the good] medicines was not a holy man but he knew all their uses and for that reason he was considered a powerful and holy man." Unfortunately, he admitted, "To-day only the poison medicines are remembered; the good medicines are all gone."[391] This story reveals that despite the persistence of many aspects of Ho-Chunk medicine ways into the early twentieth century, state efforts to eliminate Native practices and cultural traditions did inflict harm on communities. For the Ho-Chunk, the loss of "good medicines" represents just one of the many costs associated with America's colonial project.

[391] Radin, *The Winnebago Tribe*, 222.

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