

The thirty two chapters of *Harbors, Flows, and Migrations* speak to “a wide range of diverse interests in its readers, bearing witness to the lively international and transnational debate with the field of American Studies today” (10). This is not a “dangerous trip” in the sense explored in chapter nine, but it is a challenging one that will resonate with any reader who wishes to understand the present in the light of the past, and who is particularly attuned to the changing face of America today. The “harbors, flows and migrations” described in the volume are part of modern daily experience; they are on the news, they are in America and they are in the world. All works that contribute to our comprehension of this important feature of modern life have a special role to play in enhancing our understanding of the present. *Harbors, Flows, and Migrations* can be read in its entirety or as separate chapters. It is a volume to which one can return over and over again and still find new insights into the past and, perhaps most importantly of all, America’s somewhat troubled present.

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Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s*. Toronto: University of Toronto Press, 2016. 288 pages. ISBN: 1-4426-4557-8.

Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s provides a poignant look at colonialism, discrimination, and negligence in Canada through the lens of segregated healthcare. Maureen K. Lux’s study traces the rise and fall of the “Indian hospital” system, which sought to contain the perceived “threat that Aboriginal contagion posed to society” –both physical and moral – by coercively isolating Indigenous bodies (9). By the 1960s, the Canadian government owned 22 understaffed and under-equipped Indian hospitals, where thousands of First Nations and Inuit women, men, and children received (most often) inadequate treatment and were frequently subjected to nonconsensual experimentation and outdated surgeries. By effectively linking the history of Indian Health Services to the broader project of Canadian colonialism, including the reserve structure, residential schools, and resource extraction, Lux demonstrates how “ultimately Indian hospitals isolated and treated the consequences of colonization and operated to maintain if not widen health disparities” (17). Too little

has been known about this explicitly segregationist policy and its disturbing accompanying practices, even though this past is still very close to us. Lux's important work causes us to pause to take stock of how settler society's prejudices and willingness to turn a blind eye produced these inequities with ongoing ramifications.

A key argument of the work is that Indian Hospitals were framed by the Canadian government as humanitarian aid rather than as a legal obligation to First Nations and Inuit peoples. First Nation signatories understood the Treaties to include healthcare and medicines. The Government, however, did not acknowledge these terms or, at most, subscribed to a literal reading of the "medicine chest clause" (for example Treaty 6). As a humanitarian "gift" to communities, "Indian" healthcare policy could be haphazard and cost-cutting, and served to position "Aboriginal people as the objects of charity" (7). Yet, the dilapidated buildings, unlicensed medical staff, and punitive discipline (for example, putting children in full body casts to ensure they stayed still!) revealed in *Separate Beds* shows patient experiences were a far cry from a "gift."

Indian hospitals emerged as a response to the threat of tuberculosis (TB), even though it was not the main cause of illness and death among Indigenous people in Canada during the studied period. Lux demonstrates how Indigenous bodies and spaces became politically bound to TB because of the classed and racialized notions of "character" that the disease implied. Not deemed sufficiently civilized to benefit from the sanatorium treatments befitting white settlers, First Nations and Inuit patients were, instead, subjected to invasive testing (including dangerous regular x-raying) and compulsory hospitalization and surgery, under threat of arrest. Tuberculosis was spread rather than eradicated by Indian hospitals, as TB patients were roomed with non-tubercular patients, including pregnant women, the elderly, and children. When TB rates began to fall, tuberculosis patients in Indian hospitals in 1965 were, nonetheless, forced to stay in hospital for an average of 17.93 months – compared to 8.63 months for non-Indigenous patients – in order to minimize hospitals' per diem expenses and maximize patient fees (67).

In the Introduction, Lux situates the study as building on personal narratives of life in Indian hospitals, stating that "it contextualizes these threads of experience in the larger fabric of twentieth-century health policy" (17). Lux clearly depicts hospital and healthcare structures and policies and informs us of the attitudes of medical and Department of Indian Affairs offi-

cials. The occasional voices of former patients add an important perspective to the study because the upsetting details of hospital operations make us want to hear about those who survived. However, on this point, Lux makes a significant argument that carries well beyond the scope of this particular study. She states, “it is important that historical interpretations that stress the people’s agency through narratives also provide the historical context of the coercive nature of IHS policies and its close collaboration with police and courts lest they imply that resistance and resilience somehow mitigated the damage done to communities and individuals” (113). To emphasize this important point further, she adds: “Historical interpretations that foreground resistance as survival, without inquiring into its wider social, political, and economic contexts, relieve us from confronting the conditions that made resistance necessary” (114).

While the hospital experiences presented in the work are shocking, Lux complicates the narrative by emphasizing the value of the Indian hospitals for many First Nations and Inuit communities, for whom they were critical access points for medical care and, further, were viewed as an important part of the government’s obligations. The work effectively demonstrates the multiple levels of Indigenous activism on the issue of Indian hospitals; from First Nations and Inuit hospital staff who acted as “cultural brokers,” to patient organized in-house Native Councils, and to an array of chiefs and communities who advocated for improved Indigenous healthcare. Lux convincingly argues that activism tied to healthcare and Indian hospitals offers a model of Indigenous political organization/activism resurgence that predates the White Paper (162).

The book will certainly be valuable to anyone working in North American studies or the history of medicine, and would be an excellent, eye-opening fit in many undergraduate or graduate courses. *Separate Beds* ties the stomach into knots and makes the blood boil – and that makes it a resounding success. Instead of imposing her own critical voice, Lux commendably allows Indian hospital administrators, policies, and conditions to speak for themselves. Only in the final chapter, “The Government’s eyes were opened,” do we get a sense that Lux cannot hold back her anger, which the reader has already long been trying to contain. With Maureen K. Lux’s impressive study, the history of Indian hospitals in Canada will not easily be ignored again.