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Colonialism in Cold War Alaska"

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Introduction

CHRISTOPHER BRICK: Hi. This is Christopher Brick here on behalf of the OAH Committee on Marketing and Communications. Welcome back to *Intervals*, a public humanities podcasting initiative of the OAH, and today a special welcome also to Dr. Tess Lanzarotta, a historian of science and medicine at the University of Toronto School of Public Health and a specialist on the history of Indigenous health and healing. It's Tess's work and interest in this area that drew her attention to the history of tuberculosis mitigation in Alaska during the mid-20th century - a time when European imperialism, tottering in much of the Global South after centuries of plunder, atrocity, and misrule, gave the appearance of an arrangement that was in decline more generally.

Nowhere though is colony collapse evident in the place that we encounter in Tess's talk, which tracks Alaska's midcentury transformation from a non-contiguous territory at the US periphery into a front-line staging ground of the early Cold War, the 49th American state, and the coveted object of resource-extractors in industry and government alike.

None of these powerful interest groups notified Alaska Native communities of their new commercial and geostrategic significance. They communicated their meaning instead by sending teams of public health specialists to curtail the spread of infectious diseases like tuberculosis amongst Indigenous Alaskans. This was an approach long in keeping with the playbook that European empires employed to reorganize local conditions around the needs of settler populations and to convert the people they were colonizing into a more disease-resistant labor force.

It also sounds a lot like the tuberculosis control campaigning that the US public health authorities began to intensify in the 1940s, and which Tess's work in this area engages.

That the United States bears responsibility for a great deal of atrocity against Native and Indigenous peoples throughout the Americas is inseparable from its history as a settler-colonial state, and this lecture opens with the scene of a mass disinternment in Sitka, Alaska that reminds us this history extended well into the 20th century, well into the Cold War era, and well into the contemporary Arctic -- a region whose experience has a lot more to tell us all yet, Americans and

Canadians alike, as Tess Lanzarotta's work makes clear.

Lecture

TESS LANZAROTTA: In April 1946, a bacteriologist named Susan Meredith wove her way through the crowds at the Lake Union shipyard in Seattle, Washington while she searched for her new employer. Meredith had some apprehension about the journey she was about to undertake. She'd be sailing north to Juneau and from there would travel the coastline of Alaska to track an unfolding tuberculosis epidemic. During World War II, Meredith had joined the workforce, like many other American women - she'd first worked at military laboratory, and then at a Seattle hospital, jobs she found "necessary, routine." As the war came to a close, many women, even those with extensive education and experience, faced enormous pressure to leave their jobs and return to domestic life. Meredith, for her part, wasn't prepared to do that.

She would later recall that as a child she'd contracted polio and spent months immobilized in plaster casts. To pass the time, she'd read adventure novels and fantasized about a future as a cowgirl, or a sailor.. she'd wanted to do something out of the ordinary with her life. And so, when the war ended, she wrote to the Department of Health in the Alaska Territory to ask whether any coastal villages were interested in hiring a bacteriologist. A few weeks later, she received a response, informing her that, while there were no job openings in villages, there was a position available on a mobile clinic on a boat called the *Hygiene* for a someone to serve as both a bacteriologist and an X-ray technician. At the

time, Meredith had no idea how to operate an X-ray machine, but she was confident that she'd be a quick study, so she enthusiastically accepted the opportunity.

On board, she would encounter a number of other women in similar situations - doctors, nurses, and lab technicians who saw traveling to Alaska as an opportunity for both meaningful employment and adventure. At the time, the Alaska Territory loomed large in the American imagination as a final iteration of the myth of the frontier - as one of Meredith's colleagues would put it, "Alaska is the last frontier. It offers many opportunities to those who would pioneer.. It is a strange land of contrasts, modern and primitive." This idea - that once could at once experience primitive conditions and participate in the creation of modernity - has always been at the very core of the idea of the American frontier.

But the myth of the frontier has also fundamentally functioned to gloss over the violent realities of American territorial expansion and settler colonialism. As much as the effort to combat tuberculosis in the Alaska Territory was a humanitarian endeavor, it was also a colonial project accompanied by a vision of Alaska's future that included militarization, white settlement, and the development of extractive natural resource industries. Colonial officials also assumed that, as the American presence in Alaska grew, Alaska Native peoples would assimilate into mainstream American society, abandoning their subsistence lifestyles in order to become workers in a capitalist economy.

The approach to combatting the tuberculosis epidemic reflected these assumptions. The tuberculosis program - in its various iterations -- was also shaped by the idea that health crises in Indigenous communities offered opportunities to test experimental treatments. As you'll hear, doctors and health researchers viewed Alaska as something of a natural laboratory... a place where the existing health infrastructure was so sparse and the disease burden so heavy that drastic forms of intervention were justified, even necessary. This way of thinking had profound consequences for Alaska Native peoples. As I'm sure many of us have come to realize during the past year, both the direct consequences of an epidemic and the interventions designed to combat it can be disruptive and lead to physical and emotional suffering.

This is especially true when vulnerable people are told to take actions to stop the spread of disease that come with a complex calculus of risk that involves weighing one's own needs against those of a family or community, or weighing the need to secure one's livelihood in the present against possible health risks in the future. Sometimes, for various reasons, public health directives, now and in the past, have proven difficult or even impossible to follow. The story of Alaska's tuberculosis epidemic is often held up as a public health success story - and in some ways, that's well-deserved, by the 1970s the death rate from tuberculosis in Alaska was near zero and the spread of the disease was largely controlled. But I think, and I hope, that this history will reveal that darker histories often lie latent beneath our stories of biomedical progress.

So, I'm going to begin this story in the 1940s, and discuss the first major effort to gather statistics on rates of tuberculosis in the Alaska Territory, and particularly in Alaska Native communities, which were hit hardest by the disease. The diagnostic process was sometimes disturbing for both Alaska Native village residents and for the clinical staff - the doctors, nurses, and laboratory technicians - who were involved. Then, I'll move forward to the late 1950s, when hundreds of Alaska Native individuals suffering from tuberculosis were transported from their home communities to distant hospitals in Anchorage, Juneau, and Seattle. I'll then talk about the beginnings of outpatient tuberculosis care in Alaska and finally, I'll touch upon the legacies of the tuberculosis epidemic...

The story of the diagnostic campaign begins with a doctor named C. Earl Albrecht. Albrecht had first arrived in Alaska in 1935 to take a job at a new hospital in the Matanuska Valley - an area of rich farmland northeast of Anchorage where several hundred Midwestern families had been resettled as a part of the New Deal, during the Great Depression. Albrecht was the son of a Moravian minister, and was a devout Moravian himself, and he hoped that his time in Alaska would involve missionary work (the Moravian church has a long, if checkered, history in Alaska). But, during the Second World War, Albrecht found himself in unexpected new role -- he was called upon to act as the administrator of six military hospitals, which were scattered across the Alaska Territory.

After the War, he was offered a position as the first health commissioner for the Alaska Territory; the territorial legislature had only just created a

Department of Health in 1945. At first, Albrecht was wary of the offer - he liked clinical medicine and hadn't imagined a career trajectory where he'd end up as an administrator or a policy-maker. But, he'd also traveled extensively across the Alaska Territory during the war and he'd observed what appeared to be high rates of tuberculosis in Alaska Native communities. He wanted to improve the situation. So, Albrecht came to see serving as health commissioner as an alternative to missionary work - he believed it was his calling, the path that God had chosen for him, and he approached it with zeal.

Albrecht convinced the secretary of the interior to request that the American Medical Association send a team to Alaska to conduct a health survey. The team spent three weeks in Alaska, travelling some 4500 miles from Ketchikan, a picturesque, if rainy, coastal community on the panhandle, to Utqiagvik, the northernmost village in the state, bound by polar tundra and the Arctic Ocean. The team was shocked by what they found during their journey. In Kotzebue, a village with a population of some 600, a local doctor reported that, according to his records, over a four-year period, tuberculosis had been responsible for more than half of the deaths in the village.

The team's report emphasized that tuberculosis stood to stunt Alaska's economic growth. "To the industrialist and employer who think in terms of production," the report explained, "a labor market grossly infected with tuberculosis is an economic liability." The report also pointed out that tuberculosis knew "no color line," suggesting that even though the disease was disproportionately impacting Alaska Native communities, it could and,

probably would, spill over into Alaska's growing population of white settlers. In short, the American Medical Association team were less concerned with the health and wellbeing of Alaska Native people, and more concerned with how an epidemic of tuberculosis in Indigenous communities might impact the viability of Alaska as military outpost and as a colony available for white settlement and industrial development.

However, to secure sufficient federal funding to implement comprehensive prevention and treatment programs, Albrecht knew he would need more evidence - more data -- demonstrating the severity of the tuberculosis epidemic. He successfully petitioned the Bureau of Indian Affairs and the Public Health Service to provide funding for a case-finding mission. But, many communities in the Alaska Territory were difficult to access and the distances between them were enormous. At 663 thousand square miles, Alaska is more than twice the size of Texas, the next biggest state, which made surveying the entire territory was a daunting task. But, Albrecht saw a possible way forward.

During World War II, the military presence in Alaska had grown dramatically, and had led to the building of new docks, wharves, hospitals, railways, and roads, like the famous Alaska Highway, the construction of which was approved after the Japanese bombed Pearl Harbor in the Hawaiian Islands and Dutch Harbor in the Aleutian Islands. When the war ended, much of this infrastructure, along with surplus military vehicles, was repurposed for civilian use. Albrecht realized it could also help him to extend the diagnostic reach of the Department of Health.

He insisted that the Department of Health purchase a decommissioned 128-foot boat from the army, which was christened the *Hygiene*. The vessel was equipped with offices and a clinic with space for a doctor, a nurse, dental assistant, a secretary, and a lab technician who would travel along the coast with the ship's crew conducting x-rays and blood tests, distributing educational public health materials, and offering vaccinations and basic dental examinations.

The Board of Health also acquired several barges, including the *Yukon Health* and the *Hazel B*, which would travel up the shallower waters of the Yukon and Kuskokwim rivers, reaching remote communities in the Alaskan interior. Mobile Health units that resembled short school buses with attached trailers also traversed the Alaska Highway and two railway cars were transformed into clinics that traveled along the Alaska Railroad. But, the boats were the backbone; a significant portion of Alaska's population lived along waterways and floating clinics were the easiest way to reach them.

And now I want to return to the moment where I started this story, when Susan Meredith joined the crew of the *Hygiene* in 1946, and talk more about her experience of life on board. After leaving Seattle, Meredith became fast friends with a public health nurse named Catherine, or Kitty, Gair, which was fortunate, given that they would be spending months in close quarters and would be working together. Upon meeting, the two women discussed their jobs, each curious to know more about the role that the other would play in the ship's operations. Meredith was relieved that her job was dramatically different from Gair's. As a public health nurse, Gair was supposed to educate people

on how to keep themselves healthy. But she would also be called upon to do clinical work, and she was worried that this responsibility would overwhelm her and limit the time she had to spend on her teaching. "These considerations did not bother me," Meredith recalled, "since my job was clearcut - or so I thought."

She quickly realized that her role would come with emotional challenges that she hadn't anticipated. The ship was constantly behind schedule - in part because they'd misunderstood the seasonal rhythms of life in rural Alaska - in the warmer months, people were often away from their communities at fishing or hunting camps, and the ship sometimes had to wait for them to return. The weather was also unpredictable, and communication was a problem; radios were sometimes unreliable and the Hygiene might dock to find that the community hadn't been warned of their arrival, which meant that diagnostic process was chaotic, disorganized, and rushed.

Meredith also realized that their presence was a source of considerable anxiety for Alaska Native people. Meredith quickly began to have doubts about the value of their work - she wrote a letter to her mother a few months into her voyage expressing her growing ambivalence...

We have had a busy, interesting, yet for me discouraging month [she wrote] ... I am having a hard time with my feelings about what we are doing. I know it has to be done, but I feel like a machine. The people flow through the clinic and my only contact is to tell them or the interpreter... "Take a deep breath and hold it." Then I punch the button...

My only other contact is when I draw blood from their veins... and they are scared to death...

Now, this fear didn't necessarily stem from a lack of familiarity with western medicine or with white outsiders in general. Of course, Alaska Native communities had their own healers, who treated illnesses, including tuberculosis, according to their own healing systems and with medicines made from local ingredients. In some regions, contact with Russian traders, missionaries, and physicians had also influenced Alaska Native healing practices. And, by the early 20th century some larger communities had clinics that were staffed, at least for part of the year, by American doctors or nurses. By mid-century, the residents of some communities also accessed medical care by agreeing to participate in biomedical research in exchange for treatment. Even in fairly remote communities, then, many Alaska Native people had come to expect that the arrival of white doctors signaled an opportunity to have their ailments treated. In the context of tuberculosis diagnostic surveys, these expectations led to uncomfortable clinical encounters.

Meredith's letter to her mother went on to explain: *We are gathering lots of information, but the discouraging part... is to tell these infected people, "Yes, you are very ill, but we cannot do anything for you now." I have the feeling they are expecting much more than being told to rest and stay away from other people. There are simply no beds to put them in.*

Meredith recalled that "People willingly submitted to X-rays and blood tests." But, if tests confirmed that they had tuberculosis, then they were simply

given a lecture on isolation techniques, diet, and rest, and left to wonder whether a hospital bed would ever become available for them. Most Alaska Native communities were small and tightly-knit - homes housed entire families who lived together in close quarters. They relied on physically-taxing subsistence activities, like hunting, fishing, whaling, trapping, and gathering fruits and vegetables for food, and even the process of preserving food to last through the long winter months could be labor intensive.

For many, isolation and prolonged bed rest were simply not feasible. In some villages, nearly 20 percent of the population tested positive for tuberculosis - in such cases, it was impossible to imagine that those with tuberculosis could stop contributing to community life, even if their health was steadily declining. Indeed, in one of her reports, the doctor on board the *Hygiene* declared isolation to be an "impossible" goal and insisted that the epidemic would only be stopped when all active cases could be hospitalized.

By 1949, there were nearly 135,000 people in Alaska and 5,900 cases were listed on the tuberculosis register. But, there were only 439 hospital beds, and tuberculosis remained the leading cause of death.

But, tuberculosis wasn't the only health condition that the *Hygiene* encountered, nor was it the only one that confounded the crew's efforts to provide assistance. For example, the *Hygiene* was outfitted with an audiometer to perform hearing tests; but, the ship's motor was too loud to use it onboard, so it had to be carried ashore. "Lugging its 40 pounds over slippery seaweed on rocky beaches," Meredith

remembered, "was an acrobatic feat." She recalled one older man "whose face had lit up when he heard sounds through the audiometer." He told her that he wished there was a machine that could help him hear all the time. But, there were no hearing aids available in the Alaska Territory. "It was hard to explain to people in outlying villages," Meredith explained, "that a solution to their problem was only feasible if we could demonstrate that enough cases were present to make it financially worthwhile to treat them." Having to acknowledge that they didn't have the resources to address curable health problems was, as Meredith put it, "discouraging."

The *Hygiene* often returned to the same villages year after year to follow up on diagnoses and see whether patients were improving. But increasingly, the staff noticed that they were treated coolly. The residents of Alaska Native communities were more reluctant to submit to x-rays, and began to openly question the usefulness of the case-finding mission. In 1948, the *Hygiene* arrived in a village on the Aleutian Islands, a place it had first visited two years earlier. According to the doctor's report, none of the tuberculosis patients in the village had been hospitalized. Instead, the doctor noted that all the cases had "advanced, and many new ones had appeared." The community, which the doctor had felt was "flourishing" two years earlier, had become "economically insecure" and many of the residents were seen to be "drinking heavily."

Naomi Fox, a nurse who served on a mobile health unit that traveled along the Alaska Highway, expressed a similar set of concerns and frustrations. Communities were alerted of Fox's

imminent arrival either through a radio transmission called "Tundra Topics," or by word of mouth, and clinics were set up in schools, roadhouses, or private homes. The area Fox served was mostly populated by Athabascan-speaking peoples living in small communities in the Alaskan interior. Some of them would travel nearly fifty miles to receive medical attention from the mobile health unit; for some that was actually a relatively short distance, compared to the journey to Fairbanks, where the nearest major clinic was located. But, reflecting on her work years later, Fox recalled that much of the time she had felt "helpless." She particularly dwelt on the memory of one specific conversation in which she learned that one of her patients had witness, in just five years, the population his village drop from twenty-five to eight as a result of tuberculosis.

Public health nurses like Naomi Fox and Kitty Gair also circulated educational literature that was intended to promote proper tuberculosis prevention and care techniques. One booklet, a 117-page guide called "Home Care of the Tuberculous in Alaska," aimed to educate readers on how to care for those who could not be hospitalized. It told the story of Sally Brown, an Alaska Native teenager with tuberculosis whose family took care of her and made sure that she recovered. The story concludes with Sally enrolling in a business course and getting a job as a secretary, again suggesting that public health officials imagined that joining the workforce was the reward for, or even ultimate goal of, tuberculosis recovery. One can imagine how far removed the storyline in the booklet must have been from the experiences of those suffering from tuberculosis and their worried family members.

It's perhaps not entirely surprising, then, that some patients also simply ignored or denied their diagnoses. In one community, a nurse ended up in a long argument with a mother and father who insisted that their son, despite displaying symptoms of advanced pulmonary tuberculosis, wasn't sick and didn't need bed rest or hospitalization. Meredith thought that the boy's parents had responded this way, because admitting the presence of.. the disease.. meant acknowledging that their son had been dealt a death sentence." As they left, Meredith remembered feeling "depressed" about the situation. The case-finding mission was clearly disrupting community life in ways that the medical staff hadn't anticipated, especially Meredith, who'd left Juneau so optimistic about her seemingly straightforward job.

Some patients hoped for eventual hospitalization, because it seemed to offer better prospects for healing. In fact, in one community near the tip of the Katmai Peninsula Gair learned that a local man had set off with his family for the tuberculosis hospital in Seward, more than five hundred miles away, because he was determined to convince the hospital staff to admit him. A local teacher told the staff of the Hygiene that after the ship had departed the previous year "the villagers had besieged them with questions about the forthcoming hospitalization which never came." But others feared hospitalization, knowing full well that it would mean a lengthy separation from their families and communities, and that it came with the very real possibility of dying alone and far from home.

Regardless, there simply weren't enough beds in Alaska. But, Meredith hoped that the work she was doing would help to rectify that. On one level, she

felt strongly that isolation through hospitalization was the only way to halt the spread of tuberculosis. But, on another, she thought that hospitalization was important because it would restore Alaska Native peoples' confidence in the intentions of the clinic staff and public health officials. And, I think it's likely that Meredith and her colleagues also felt that, if the hospitalization of active cases became a possibility, then the suffering their work caused would ultimately be proven justified.

By the early 1950s, Albrecht had convincing statistics regarding the extent of the epidemic and appealed to the Department of the Interior to send another team to assess the health of Alaska Native peoples. Once again, it seemed as though the evidence that had been collected was only sufficient to prove that there was cause to gather more evidence. In Summer 1953, a team led by former Surgeon General Thomas Parran, arrived in Juneau. The report that the team produced, usually called *The Parran Report*, marked a pivotal moment for the campaign against tuberculosis in the Alaska Territory. The report recommended a two-pronged solution involving the introduction of pharmaceutical treatment -new chemotherapy drugs had recently been developed -- and the mass hospitalization of active cases in Washington State, where there were open hospital beds.

The report also issued strong cautionary statements about what America stood to lose if Alaska's tuberculosis problem wasn't solved, and solved expediently.

Several members of our... group [the report explained] have participated actively in the

important task of bringing aid to the "underdeveloped countries." It has been a rewarding experience to see firsthand what American technical skills... can do to invigorate... hapless, hungry, dying people in foreign lands. We believe sincerely in what our program of technical assistance is doing... to make friends and allies for the United States. We believe sincerely also that the United States will stand in greater honor in the free world if we practice what we preach to other nations and apply our technical skills more fully to the grave problems in our northern backyard.

During this period of the Cold War, the United States was seeking to expand its international influence by demonstrating that technocratic leadership and capitalist economic development could lift people out of poverty, and could do so more effectively than the policies of the Soviet Union. The Alaska Territory, according to the Parran Report, could serve as a model for what it called "underdeveloped countries." Parran and his team also suggested that hospitalization, while primarily oriented around restoring physical health, also offered an opportunity for education and vocational training, which might help former patients secure gainful employment upon discharge. In their view, Alaska was changing and Alaska Native peoples needed to change along with it.

Of course, there were some tuberculosis hospitals in the Alaska Territory, and I want to talk a bit about the work they did before discussing the transportation of Alaska Native patients to Washington State. In February 1947, the newly renovated Mt. Edgecumbe Hospital at Sitka, had opened just in time to receive its first ninety-one patients, who arrived by boat from communities

across Alaska. At Edgecumbe, a special orthopedics ward had been built to treat patients suffering from bone tuberculosis, most of whom were children. Bone tuberculosis occurs infrequently now, but in the past, it was most common in children. That's because tuberculosis is a disease that thrives in an oxygen rich environment, and the bones of children are more vascular than those of adults, ...

Before the Mt. Edgecumbe hospital opened, Albrecht had flown to Colorado and convinced a surgeon named Philip Moore to come to Alaska and run the orthopedics unit. Moore actually didn't have much experience with bone tuberculosis, but he used his professional connections to draw attention to Alaska as what he called "the most marvelous test tube for learning about tuberculosis of any place in the world." He was able to convince several prominent surgeons to visit his clinic, so that he could watch them work and learn from their expertise. The hospital soon developed a reputation as a place to test experimental surgical techniques.

For instance, patients who needed surgery on their spine or joints would typically require bone grafts after the tuberculous tissue was removed. These grafts were often taken from the patient's own iliac crest; but, because most of Moore's patients were young children, they often didn't have the necessary bone mass for this procedure to be performed safely. Moore needed a different source of bone tissue. Fortunately for Moore, one of the other doctors at the Mt. Edgecumbe hospital regularly performed a surgery called thoracoplasty on pulmonary tuberculosis patients.

During a thoracoplasty, several of the patient's ribs were removed, so that the lung, and tuberculosis cavities along with it, would collapse, which limited the flow of oxygen and halted the progress of the disease. Sometimes, the patient's chest wall was then held up with a structure made of paraffin wax, so that it would retain its shape. Moore realized that he could take the ribs removed during these surgeries, grind them up, and then use the material to fill the cavities that were left when he removed diseased bone from his young bone tuberculosis patients. He kept the specimens frozen on dry ice in what he called his "bone bank." Moore also started performing these surgeries in the field --- he would fly to remote communities, sometimes traveling the final miles by dogsled, with the frozen bone tissue in an insulated case, and perform the operation in a small local clinic or even a schoolhouse, if a clinic wasn't available.

The circumstances at Mt. Edgecumbe were far from ideal. "Patients seldom got out of the hospital," one nurse recalled. "They went there to die." Some patients were in the hospital so long that they had no memory of life outside or learned to communicate with one another through forms of sign language they'd invented - because, of course, patients came from across the Alaska Territory, which was and is home to diverse Indigenous societies, so patients didn't necessarily share a language or culture with one another. Patients who were small children also provoked particular concern for the hospital staff, because by the time they were discharged, they'd often lost the ability to speak their Native language.

The hospital had "standing orders for narcotics," and many of the patients, in an effort to manage their chest pains or coughs, eventually became dependent on drugs. Patients also complained that the food they were served was inedible, consisting of spoiled reindeer meat and "decaying fish... caught from spawning creeks." Missionaries often visited the hospital and tried to convert the patients. One of the nurses recalled that she had later learned that missionaries had been telling children that "they wouldn't have... [tuberculosis] if they hadn't sinned." It is unsurprising, then, that it was sometimes a struggle to persuade parents to send their children to Mt. Edgecumbe.

After the release of the Parran Report, Congress approved over a million dollars in funding to send Alaska Native patients to tuberculosis hospitals in Seattle. The number of beds available in Alaska had increased after the opening of a new hospital with 300 tuberculosis beds in Anchorage in 1950, but some 2000 patients still needed a bed. Three hospitals in Washington State, the state-owned Firland Sanatorium and two private facilities called Riverton and Laurel Beach, had space for five hundred patients between them. The Department of Health moved quickly -- more than four hundred Alaska Native patients had reached Washington State by the spring of 1955.

In this next section, I'll be relaying some of the experiences of Alaska Native patients who were hospitalized in Washington State. But, I should acknowledge that this information was filtered through the lens of a white observer, an anthropologist named Margaret Lantis. She saw the hospitalization program as an opportunity for research and managed to acquire funding from the US

Public Health Service to study how hospitalization impacted Alaska Native patients and to observe how well the staff of the hospitals coped with a patient population who often spoke little to no English. It's from the records of this project - the interviews she conducted with patients and with hospital staff - that I'm piecing these stories together. And, I'm not at liberty to mention the names of specific patients or to identify the communities they came from. So, any vagueness in this next section is out of concern for the privacy of former patients.

For many Alaska Native people, their journey to Washington State was abrupt and confusing. In the early 1950s, the wait time for a hospital bed had been as long as two years, but with the opening of the Seattle hospitals, it was cut to several months. The stretch of waiting time had been frustrating, but it had also given hospital staff ample time to send letters to regional nurses, who would then inform patients that they had moved up the priority list. Once the process began to move more quickly, many patients had little warning of their departure, and only had enough time to gather some essentials before boarding a plane, often for the first time. It wasn't uncommon for patients to leave without saying goodbye to their families and they often didn't know whether their final destination was Sitka, Anchorage, or Seattle until the plane landed.

Patients' destinations were, at least to some degree, medically determined. At the hospital in Anchorage, one surgeon confided to Lantis, saying: "Of course, we keep the most interesting surgical cases here. That's human nature." Then, he regretted his candor and asked Lantis not to tell

anyone at the Seattle hospitals what he'd said. Whether she kept this promise or not, she recorded the statement in her notes. Patients tried to influence the process as much as they could by asking to be hospitalized in the same place as their family members. And, they were bitterly disappointed when these requests weren't granted.

Anxiety surrounding hospital placement affected both patients and their families. For instance, a five-year-old girl from an Arctic coastal village arrived at the Firland Sanatorium in August 1955. The nurses wrote to her parents, informing them of her safe arrival, giving them information about the other children she shared the ward with, and letting them know that they could send money for candy or other treats. The girl's parents quickly wrote back: they had been told that she was in Anchorage, and had repeatedly contacted the Anchorage hospital asking for information about their daughter, but had never received a response. They'd been terribly worried, unable to locate or contact their young, sick child. They expressed gratitude to the Firland nurses, and asked if their daughter wanted anything or if her condition had improved. They also asked how she had arrived in Seattle - by plane or train - and expressed that they were shocked to hear that she was so far away. Their final request was a photograph of their daughter.

In another instance, Lantis met with a couple who'd been in the hospital for nearly a year and a half. Hearing that they'd been cleared for discharge, Lantis asked the female patient what she was looking forward to doing when she returned home. The patient responded simply that she "would take care of her family." It was quite common for

children to be put into foster care while their parents were in hospital, and some parents returned to learn that their children had been sent to boarding school in their absence. Perhaps overwhelmed by her desire to return to her family before any such actions were taken, the patient started to cry and told Lantis that "white people had promised her and... [her husband] that they could go home last December, but hadn't discharged them... she was afraid that there would be a second disappointment." This struck a chord with Lantis - just a few months earlier she'd learned of a patient in Anchorage whose return home had been delayed because the hospital was waiting for break-up (that's the period each spring when sea ice melts and travel becomes easier). The patient had become "discouraged" and then "jumped from a fourth floor window."

Another patient told Lantis that he was worried about returning home -- someone from his village had written to tell him that his entire team of sled dogs had died, because there was no one to take care of them, and he wasn't sure how he'd get by without them. At Firland, patients were so unhappy with their treatment that they collectively wrote to local newspaper editors in an effort to expose a guard who had beat a patient, causing him to hemorrhage; I'm not sure if their letter was ever published.

Patients also relayed experiences of racism - hospital staff criticized their hygiene and behavior. Some struggled to adapt to the regimented routines of daily life in the hospital - they were only allowed a certain amount of time out of bed - what was called "up time" --, usually just a few hours each day, and hospital staff tended to

interpret patients' resistance to this as a sign of their lack of discipline. One woman told Lantis that she and a group of patients had been laughing and talking late one night when a nurse came by and told them to shut up, because they sounded like "a pack of dogs." This insult was a particularly offensive one. Until the end of World War II, segregation had been legal in Alaska and business-owners in cities had hung signs that read "No Natives and No Dogs." It's very likely that Alaska Native patients had seen such signs or at least heard about them.

For people used to spending much of their time outdoors, and used organizing their lives around the seasonal rhythms of lands and waters, it was hard enough to spend months or years trapped in a hospital. As one patient later wrote, he felt like "a bird in a cage with nowhere to fly." But, on top of that, Alaska Native patients had to place their trust in white medical staff, many of whom harbored the very same racist ideas held by American settlers in Alaska. Lantis marveled that patients were willing to tolerate the hospital staff, the patients, she noted "have been lined up, vaccinated, x-rayed, or otherwise jabbed, swabbed, or scrutinized,".

Within a few years, there were empty hospital beds in Alaska. However, federal funding had been provided only to pay for the transportation of patients to Seattle, not to cover the cost of operating existing hospitals in Alaska at full capacity. Bureaucratic logic, then, shaped the epidemic response at least as much as concern for patients' wellbeing.

Of course, some of the staff were kind and compassionate and formed close relationships with the patients they cared for. And not all patients experienced hospitalization the same way. Some of the patients were enthusiastic about the opportunities for education and vocational rehabilitation that were offered in the hospitals. But, these training programs didn't always translate well into the realities of village life when patients returned home.

One former patient returned to his village after two years of hospitalization. He told Lantis that he had learned to use a tape recorder, a camera, and "other gadgets" in the hospital. He was proud of these new skills and hoped they would help to get him a job at a Distant Early Warning Line radar site. The DEW line sites, as they were known, had been constructed along the Arctic Coast in the mid-1950s to warn of approaching Soviet bombers. The patient's plan seemed reasonable - in 1956, the Air Force had agreed to begin hiring Alaska Native personnel for jobs at DEW sites, which had previously been reserved for white servicemen. But, the former patient was told that the DEW Line would not hire former tuberculosis patients and, Lantis noted others in his village were starting to make fun of him, claiming he hadn't learned anything in the hospital after all. After hearing this story, Lantis wrote to officials who operated the DEW Line sites, imploring them to hire returned patients who desperately needed work. It's not clear from the archival record whether her exhortations made any difference.

The patients who seem to have benefitted most from vocational training were those who became interested in healthcare. In 1951, Mt. Edgecumbe

hospital had started a year-long nurse training program, and many of those who enrolled were former patients. They generally reported that they quickly found jobs at regional hospitals or clinics. In Seattle hospitals, the staff offered classes that trained patients as public health educators or as aides to public health nurses. And, as chemotherapy drugs were introduced as a form of tuberculosis treatment in rural Alaska, these skills would become more valuable..

Some patients, in Alaska and elsewhere, had been treated with streptomycin since its introduction in 1947, but it was expensive, in short supply, could generate resistance, and often offered only temporary improvement. By the early 1950s, though, several new and more promising drugs had been developed. In 1949, para-amino salicylic acid (PAS) first became available - it had unpleasant side effects, but when it was administered with streptomycin, seemed to prevent the development of resistance. In 1952 isoniazid (INH), was introduced and was hailed as a "wonder drug." The three drugs were used together in various combinations to support sanitarium care and the length of average hospital stays began to shrink and tuberculosis death rates declined.

In fact, according to the research of anthropologist Linda Green, in 1952 a physician named Beryl Michelson, who worked for the Bureau of Indian Affairs at a hospital in Bethel, created an unauthorized program to treat tuberculosis patients at home using a combination of PAS and streptomycin. She worked with a Yup'ik man named Michael Chase from the village of Nunapitchuk. Chases' father and brother had both died of tuberculosis, so he eager to become involved in a

program that might save others from experiencing similar losses . He distributed drugs and gave injections, and organized the community to clean, cook, and otherwise provide for those suffering from tuberculosis. However, when Parran visited Bethel during the survey leading up to the Parran Report, he discovered the program and reported it to Michelson's superior - who swiftly fired her, ending the program.

Nonetheless, the success Parran had witnessed in Bethel influenced his decision to recommend that Alaska explore the possibility of outpatient treatment. In 1954, a formal trial of outpatient treatment using a combination of INH and PAS began in central alaska. The project was managed through regional hospitals and would eventually include seventy villages - every single village that was approached to participate agreed and many that weren't approached heard about the trial through radio transmission and insisted upon being involved, .

For the purposes of the study, "chemo nurses" were assigned to each hospital. They visited each village every three months to deliver fresh supplies of pills, perform diagnostic tests, review medical records, and offer classes on tuberculosis prevention. But, in order to operate smoothly, the trial also required local assistants, who would make sure that patients were taking their medications and responding well to treatment. Many villages chose those who had returned from TB hospitals and who had some amount of healthcare training or knowledge about the disease. In 1957, Louise Lear, a chemo nurse stationed at the hospital in Bethel, wrote an article which described the program:

If you should step from a bush plane into certain small villages of Alaska, you would find a strange outpatient clinic for tuberculosis patients being conducted in a school or a store. The 'chemotherapy aide,' would be making explanations in the local dialect as he refilled medicine bottles. You would see mothers with toddlers, school children, and men climbing snowdrifts on the way to the school or store where the clinic is held.. a few dog sleds would be parked outside

Lear described the program as a "bold experiment," and expressed confidence that the project had demonstrated that outpatient care could work in Alaska.

Patients undergoing tuberculosis chemotherapy with PAS and INS sometimes took as many as 30 pills a day, even while traveling miles and miles between villages, fishing camps, and hunting grounds. In fact, part of the argument against implementing outpatient care at an earlier stage of the epidemic had been racist skepticism, on the part of nurses, doctors, and health officials, that Alaska Native patients were capable of managing such a complex drug regime. But, the results of the program showed that Alaska Native patients were not only capable, but actually extraordinarily diligent. Possibly because the threat of hospitalization still loomed.

In 1962, one of the lead researchers conducting the outpatient chemotherapy trial wrote that "the Alaskan experience may interest those who have similar problems and responsibilities bringing public health to peoples of other cultures." A story was being crafted, one in which Alaska had triumphed over an epidemic using an innovative and

experimental approach that might be implemented around the world. But the story of the epidemic has continued to unfold.. revealing less comfortable truths

In 1998, plans were made to expand the Sitka Airport. And, transportation officials needed remove a concrete storage bunker, which had built during World War II, to make way for a new road. Word of these plans traveled through the communities around Sitka and reached Robert Sam, a local Tlingit man. Sam reached out to authorities at the Department of Transportation and told them that the bunker had been used by the staff of the Mt. Edgecumbe hospital in the 1940s and 1950s as a makeshift mausoleum. It held the remains of more than one hundred Alaska Native patients who had died at the hospital. When Alaska Native families had been unable to pay to have the remains of their deceased relatives returned home, the bodies had been stacked in the bunker, instead of buried.

When they heard this news, the surviving family members of patients who'd died at Mt. Edgecumbe were outraged. Many families had never been told if, when, or how their relatives had died or had been assured they were given a proper burial. By July 2000, all but two of the sets of remains had been identified. A joint memorial service, attended by three hundred people, including the friends and family members of former patients and some nurses and doctors who'd worked at the hospital, was held at Sitka. A month after the memorial, Alaska Airlines began returning the sets of remains, each accompanied by a small piece of concrete from the bunker. Ultimately, remains were returned to sixty-

seven communities across Alaska, from the coast of the Arctic Ocean to the tip of the panhandle.

Moments like this, I think, remind us to be skeptical of straightforward stories about biomedical progress or public health victories. In this case, such a narrative belies the suffering of Alaska Native people and, in doing so, also fails to recognize the remarkable resilience of communities that were profoundly harmed by the tuberculosis epidemic and by that public health interventions that were launched in response to it.

Q+A

[segue from lecture]

CHRISTOPHER BRICK: And just by way of addendum to that I would add that the lecture and Q+A for this episode were recorded shortly before two mass graves of indigenous children were unearthed on the sight of former residential schools in Canada. These so-called residential schools were educational institutions really in name only. Their real purpose was instead to break native families apart, to divest native children of their inheritance and culture, and to forcibly socialize them into white Canadian folk ways. It's worth keeping all that context in mind as you listen to this discussion since much of the conversation and even the questions are very much in dialogue with this story of anti-indigenous policy and genocide in the American North.

[beginning of group conversation]

CHRISTOPHER BRICK: Tess Lanzarotta, welcome to the podcast.

TESS LANZAROTTA: Thank you, it's great to be here.

CHRISTOPHER BRICK: That word "frontier" is still on Alaska license plates, you know, so it's... [Laughs] This is a concept that [is] not just identified with the place officially, quite literally right, it's inscribed in sort of state licensing. But, culturally, as well, it has a lot of cachet and power. It's a huge idea, right? And that's very active in your talk.

TESS LANZAROTTA: Well, and I think it's really important when especially like, you know— I'm not from Alaska myself— being an outsider writing about Alaska, I think an important first step is to really engage with the kind of imaginaries of the place, and to try and get inside the heads of the people who are going there from elsewhere; what is it that they're expecting to find? How were they thinking about their own political purposes.

Because Alaska, I mean, you know it's acquired by the United States in 1867— that timing is not a coincidence. The idea of needing to open up new spaces for white settlement and build a new frontier at the end of the Civil War, I mean, it's really significant.

CHRISTOPHER BRICK: About this tuberculosis epidemic that your talk deals with: you say, "When the epidemic began, infection rates were so staggering and treatment options so limited that health officials predicted the imminent extinction of Alaska Native peoples." *That* is an incredible memory omission for any American who's been through

four years of high school to have never heard about, known about, understood was happening, that's staggering.

So, is that what drew you to this content? Or was it something— because I mean you have... there's a lot of real rich content in the story you tell about the discovery of these Alaska Native bodies, how they had been stashed away in this underground bunker in Sitka— thrown away really because of how they went unclaimed. So, there's a real problem with how omitted all of these stories are from our understanding of American history.

TESS LANZAROTTA: Yeah, and the story about the bunker in some ways, I mean, in some ways it just feels too on the nose as a metaphor for me, of what's sort of buried, what's omitted, what we erase, or we look away from and conveniently forget. I think the probable cause of the kind of lack of general knowledge about these events is there's a sort of multitude of different reasons why not many people have heard about this epidemic, and I think one of them is that, as you say, Alaska history is not particularly well integrated into the history of the United States.

Even for those students who do get some grounding in American Indian or Indigenous history, Alaska Native history is often not very well integrated into those narratives, in part because the political history in Alaska is quite different for AlaskaNative people, their sovereignty takes a very different form. They, for the most part, bypass the reservation era— although there are some

reservations in Alaska. And you know on another note, and, I mean, COVID-19 may change this, I do think that medical history is often seen as this sort of marginal specific thing that's, like, off over on the side, and there's a tendency not to think about, like, an epidemic as being the central thing that actually is important for the United States in terms of how they're reckoning with Alaska with Alaska Native people and what the sets of federal obligations are there. What would it look like for an international audience to witness this happening?

I think the extinction predictions themselves; that's a very common trope throughout sort of encounters between white settlers and Indigenous populations. Like, over the course of American history is this this idea that they're almost disappearing, and that's used as an excuse to take all kinds of actions at various different times, including, you know, development initiatives, including different kinds of public health initiatives, and including salvage anthropology and salvage biology, like collecting blood specimens and samples from populations that people anticipate might disappear. So it's alarmist..

CHRISTOPHER BRICK: And pretextual, it sounds like, right?

TESS LANZAROTTA: Yes, absolutely.

CHRISTOPHER BRICK: Insofar as it provides a superficially humanitarian/ideological rationale to enter into those spaces, and imposed a degree of

order upon it that's profoundly different from what was there before, and done so in many ways. And your talk goes into this in in very involuntary, invasive kinds of ways—

TESS LANZAROTTA: Well, and I think it also speaks to some older anthropological ideas that really situated indigenous people as being somewhere sort of earlier on the evolutionary spectrum than white Americans. And I do think that these extinction predictions, in some ways, are sort of ongoing manifestations of that idea that still a lot of people hold in a very latent way, that surely these are historical people and that their time is the past, and so their deaths are foretold. And that's a big part of the sort of narrative of colonization. And it's one that I think gets re-articulated in a variety of different ways over time.

CHRISTOPHER BRICK: Before we leave this issue of historical memory and narrative integration... I'm curious, is there much of a historical memory of this in Alaska itself? Like if I have gone through a social studies, kind of, curriculum in in AlaskaHigh School, am I likely to know a lot more about some of the stories you tell here or no?

TESS LANZAROTTA: That's an interesting question. My sense of that— and if anyone listening to this from Alaska is like screaming that I'm wrong, feel free to reach out, [Unintelligible] says I'm wrong. Feel free to, let me know, but my guess would be that it's probably not something that one would hear

about in school necessarily. I think that there's cultural memory in some communities, certainly.

But anecdotally, what I've been told from people living in Alaska and what I've read in anthropological works that are trying to sort of reckon with the legacies of the epidemic, is that it's often not spoken about very much, and that a lot of this... A lot of people have not— because this hasn't been given a lot of public attention— haven't had the opportunity to grieve, to reckon with the trauma they experienced, or their family members experienced.

CHRISTOPHER BRICK: Yeah, because... This isn't that long ago, no, I mean.

TESS LANZAROTTA: No, it's not. It's not.

CHRISTOPHER BRICK: This isn't in the 19th century. It's not in 1867, it's not... There are plenty of Alaskans alive today for whom this is part of their living, memory and so that silence itself is very interesting notwithstanding the enormous blight that this was.

You talked a bit about this colonial relationship because it— your talk begins and most of it takes place in a moment where Alaska still has territorial status and therefore much less capacity to self-govern.

CHRISTOPHER BRICK: So, I do want to ask about this statehood question at some point because I'm curious after if there was any really dramatic

transformational power redistribution that occurs as a consequence of entering... It doesn't sound like it based on the talk you gave?

TESS LANZAROTTA: I mean yes and no. I am, you know, not an expert political historian. But the drive towards statehood, my understanding of it is, largely white settlers who really are pursuing statehood.

CHRISTOPHER BRICK: They are probably the people who are very overrepresented in the Constitutional Convention [Unintelligible].

TESS LANZAROTTA: Yeah, and I'm trying to think about how to kind of map out the connections here, because it's a little bit like what happens is after Alaska achieved statehood in 1959 basically, they don't resolve any land claims before that happens, so the second statehood is achieved, Alaska Native activism really ramps up.

And I think that's actually remarkable, so one of the readings that I suggest along with this lecture, it sort of tracks the story of Alaska Native solidarity and activism in the decades subsequent, and I think it's really amazing that if you look at this tuberculosis story that was so socially disorganizing, that actually this incredibly powerful political movement still took shape despite that. And so, what happens is basically, Alaska the state kind of drags its heels on dealing with any real land claims issues until the Atlantic Richfield Oil Company hits their big payday at Prudhoe Bay, and the state government

realize that they're going to have to negotiate land claims if they're going to build a giant pipeline through the entire state of Alaska.

CHRISTOPHER BRICK: I didn't know that until you just told me, but I'm not surprised that that had something to do with the redress that was ultimately acquired later was contingent on the development and expansion elaboration of this resource extraction.

TESS LANZAROTTA: Yeah, and economic concerns are sort of central to the shape that Alaska Native sovereignty takes. So, what happens is in 1971 they pass the Alaska Native Claims Settlement Act, the largest land claim in American history. It leads to sort of a massive redistribution of territory and wealth in the state, but it organizes Alaska Native people into 13 for profit corporations in which they're shareholders.

So, their survival as political bodies is really tied to ongoing economic success and really therefore, to these extractive industries. And that, I mean, it's an enormously complicated story and it plays out in all kinds of really complicated ways, and in some ways I think is a sort of still unfinished project. There are still questions about tribal sovereignty and what that means in an Alaska context, what does federal recognition of a tribe mean in the context in which political power for Alaska Native people is condensed into a corporate structure?

This plays out for healthcare, and we can sort of tie this back in later, but just quickly, what ends up happening gradually over time is that Alaska Native corporations start non for profit branches that, for now, basically, are charged with health and social services in their respective regions, and that's a possibility in part because of the 1975 Indian Self-Determination and Education Assistance Act. So, these tribal health corporations, that are not linked to what we would think of as tribal authority in the sort of lower 48 sense, they're actually linked to the corporate governance structure.

CHRISTOPHER BRICK: Yeah, I like that modifier use because in the lower 48 sense we tend to think of tribal sovereignty as, I guess, analogous to kind of a foreign country.

TESS LANZAROTTA: So these are like... The nonprofit branches of for profit corporations, they do sort of health and social services, and they contract with the Indian Health Service, but they're independently run by Alaska Native corporations. And they come to inherit this model of outpatient care, that I'm actually talking a little bit about towards the end of this talk, that through grants, through the Office of Economic Opportunity, and various other bodies, they're able to sort of slowly start working on these kind of community health aid, outpatient care, healthcare programs that they come to administer, and part of the origin story of those programs is in this tuberculosis outpatient care model that's developed.

CHRISTOPHER BRICK: I appreciate you pulling all this together because there are so many prongs to what is going on in your talk -- because it starts off April 1946, we have Susan Meredith this bacteriologist. But there's also a militarism component. She had been in the military, this bacteriologist, and she's going up there to engage in public health work that has a quasi-military aspect to it, right?

TESS LANZAROTTA: There is a way in which, I think, the public health mission, you know, it's using this older military infrastructure that exists and in some ways is embodying both this militarism, this idea, the sense of sort of building up Alaska's defenses and making sure it can be a defense post.

CHRISTOPHER BRICK: Right?

TESS LANZAROTTA: And part of that is extending this kind of diagnostic reach, and at the same time, it also sort of takes on this older tradition of kind of military zeal and of wanting to-- or of not military zeal, *missionary* zeal-- and of wanting to kind of rescue people in need and feeling called to do this work. And I think, you know, both of those projects are in their own way problematic, and a colonial context study.

CHRISTOPHER BRICK: It seems like the common valence they share is that they're all implicated in the way that American empire happens to operate in this space. It's not as if this conquest resource

extractive, militarist civilizationist model is at all defunct in the Alaska territory of the mid-1950s whatsoever.

TESS LANZAROTTA: No, it's definitely not, and feeding into that too, I think, is this sort of emerging Cold War era International Development discourse that is being applied to, you know, other parts of Indian country in the United States as well and is a way that, you know, anthropologists, biomedical researchers, and policymakers are really thinking about, you know, what are the opportunities provided by the underdevelopment of these areas?

CHRISTOPHER BRICK: You do touch upon that briefly, the way that the wartime experience also, kind of, accelerates the integration of the Alaska Territory, kind of, into American imperial aspiration.

TESS LANZAROTTA: Yeah, I think the experience of the Second World War is a really important one for this story, because it's part of what's sort of accelerating this reach into Alaska and this this sense that Alaska is maybe an Achilles heel in National Defense. Particularly because they're thinking suddenly about cold weather combat and about Soviet invasions through the north, but then you also have the way in which the war is motivating these women to head northward.

Many of them, you know, they don't want to leave the work force or they sort of see their professional opportunities evaporating as the men

are reentering the workforce and they realize that Alaska is a place where they can continue to do the work they've been doing.

And in some cases they're very specifically recruited for that reason because there is an awareness that they might be willing to come up to Alaska if it means that they'll get to be in a position of a professional authority that they might not be able to access elsewhere. And then at the same time, I think, for Alaska Native people the experience of the war is a really important one, you know.

I don't get into this in the talk, but there's a historian, Holly Guise, who is Alaska Native and she's writing about the sort of World War II experience of Alaska Native people. So that's like a book that will be coming out that I think will be really exciting. Because, I mean, it's a complex story because it has these civil rights components where you have people living, effectively, in Jim Crow South segregation in their communities, being asked to be patriots and being asked to fight and defend the United States.

And I think when you see this sort of expectation of treatment that Alaska Native people have, even in these small communities, you know, they're conscious that they're owed... That they have a fiduciary relationship to the federal government, and that, like, there's something that supposed to be provided, that's not being provided, like there's a deal that's not being made good on here.

CHRISTOPHER BRICK: I'm glad you brought up the Jim Crow analogy -- or brought that connection in -- because we don't tend to think of there being much of a segregation regime in Alaska.

TESS LANZAROTTA: Well, and I think it's really important when thinking about this story of being transported to a different hospital and being hospitalized and cared for by white nurses and doctors, to consider, like... I think it's easy to, right, to think of it in a very sort of pat way as like "Oh well, it was a very culturally different place and that must have been a shock." And like it's so much more than that, like that's a very flat way of thinking about what this experience must have been like.

These are people who would have experienced profound racism, you know, at the hands of white people in Alaska-- or at the very least have heard about it. Then having to entrust these people with their care at the same time as being moved, you know, incredibly far from home. I think knowing that Alaska's history of racism is that profound and distinct isn't important for understanding, like, what relations between these groups of people might have been like, and not that they necessarily were contentious always on an individual level.

CHRISTOPHER BRICK: Right, I mean you bring up Lantis' connection that she develops, right. I mean, she's sent there very much under the auspices of this kind of colonial project that goes on in the Alaska territory, right?

TESS LANZAROTTA: Yeah, Lantis is an interesting figure. So, she did her PhD in what would have then been called "Eskimology" at Berkeley.

CHRISTOPHER BRICK: Yeah, that terminology it just blew my mind when you introduced it to me.

TESS LANZAROTTA: Yeah, and then I mean she'd spent quite a bit of time in Alaska, but she was someone who— in part because she was a woman— struggled to get an academic job, so she started working in applied anthropology, and she'd been working for the Arctic Health Research Center in Alaska, which was a government institution doing studies of sanitation and stuff like that. So, she knows Alaska well by the time she's doing this study with the US Public Health service at the hospital in Seattle.

She's a bit of an enigmatic figure, at least in my encounters with her, because I spend a lot of time trying to sort out what kind of person she was and how she felt about the work that she was doing because she does display a great deal of compassion for Alaska Native people, and she does try to act as an advocate for the patients in the hospital insofar as she can, and she's really resistant to— what she feels— is a pressure to essentialize cultural difference, like to offer things like classes on Alaska Native culture, insofar as Alaska Native culture is a thing that exists, because obviously there's, like, an incredibly diverse range of cultures within Alaska.

She doesn't think that... she thinks that what's happening is that structural issues are being interpreted as cultural ones, so she thinks that a lot of what patients go through is simply a result of, you know, they're ill. They're far from home. They miss their families like so, for instance, there's an incident—

CHRISTOPHER BRICK: So, it's more holistic, and is it more responsive to the needs and the kind of communal and cultural conventions of this patient group?

TESS LANZAROTTA: I think in some ways, but in some ways, I think it's motivated by... Her primary desire is not to act as a cultural expert, but instead to [Long pause] find ways to understand what's general and what's human about this experience of being in the hospital.

So, there's an incident in which a patient— is sort of asked how they got tuberculosis, and they tell her a sort of story about sin and misbehavior, and they sort of refused to acknowledge that they must have gotten tuberculosis from a family member, someone who shared their home with them. And Lantis writes in her notes that she thinks the hospital staff have been recording incidents like this and saying Alaska Native people don't understand how infectious disease works.

Like they don't understand their diagnosis and she says, "I don't think it is that. I think they don't want to admit to themselves— they don't want to blame their family members for their illness,

because they're lonely and they're far from home and they don't want to think about their family members in those terms." And I think that that's really exemplary of the way that she thinks—

CHRISTOPHER BRICK: [Overlapping] Well, yeah, it's interesting.

TESS LANZAROTTA: Like she tends to resist this sort of straightforward use of cultural, like— the sort of assumption that cultural difference is the explanation for everything. And instead, is also much more willing to record instances of racism and to suggest in her own notes that the behavior of Alaska native people within the hospital, their resistance to certain things, has a lot to do with the fact that they're not being treated very well by the staff.

CHRISTOPHER BRICK: You talked about her notes and I wanted to ask you about sources as well, because one of the challenges that I've heard a number of... This whole series is drawing from the incredible expertise of the historians who work in this area of public health, epidemic disease, and one of the big challenges is that a lot of these sources are protected, privileged, excluded from review by a very, very serious, very, very restrictive privacy regime.

So, how do you manage that? How do you overcome those hurdles and what have you found works?

TESS LANZAROTTA: So yeah, it's tricky. The sources that I use, I mean, there's a diverse range. A lot

of the women who were on these sort of public health boats— the nurses and technicians— kept diaries or wrote letters that they then donated to archives, so both the Alaska State Library and the Alaska State Archives have a lot of holdings to do with this tuberculosis campaign from the public health side. And the doctors on board ship also sent regular reports back to the Board of Health about what they were witnessing.

CHRISTOPHER BRICK: So, the sources you—

TESS LANZAROTTA: But in terms, [Overlapping] sorry—

CHRISTOPHER BRICK: Yeah, no. I mean, I was just going to, you know, pick back up on that, I know, with respect to Lantis, you mentioned there are archival collections pertaining to her work at Seattle hospitals too. Is that correct?

TESS LANZAROTTA: So, yeah. The way that I'm able to get more into the kind of patient experience in the hospital— and I mean it's absolutely mediated through Margaret Lantis. So her papers are in the archives and special collections at the University of Kentucky in Lexington, which is where she finished her career.

And that collection opened up while I was in grad school, so I didn't know what would be in it, so, I took a little road trip to Kentucky to find out, and I was really astonished because— so one of the things about this project that she does at the Seattle hospital is that, as far as I'm aware— and if anyone out there knows differently, please tell

me— she never published anything from it. I don't know even if it was ever actually submitted to the US Public Health service, I don't know what happened to the final version of the project. I don't have her conclusions. What I have is volumes and volumes and volumes of notes.

So, she went into the hospital, and she basically had a sample set of people and she did really, really lengthy interviews at them over a long period of time and with all the staff. And then, as patients were released, she also went back to the villages in Alaska to do follow up interviews to find out what their experience subsequent to hospitalization had been; were they comfortably reintegrating back into their life in the village, or were they struggling, and in what ways? And so that's incredible stuff to have access to. I have to admit I was extremely overwhelmed when I found it, because I didn't...

CHRISTOPHER BRICK: Sounds like a lot. Yeah, I mean, it sounds like there's a lot of stuff and—

TESS LANZAROTTA: It's a lot. I had to sign a lot of documents, and basically what I was told at the archive was I was not allowed to photograph it. That anything to do with the specific patients I wasn't allowed to photograph, I had to copy out in writing, and I did that. That was very time consuming days.

CHRISTOPHER BRICK: Well, that's really going back to...

TESS LANZAROTTA: I'm not allowed to copy down patient names or specific villages— which can make it a bit tricky, because then I think sometimes I'm being very slippery. It sounds like I'm being very general by just saying, like, Alaska native patients. I might be able to at least venture an educated guess about the sort of specific community that a person is from, how they might have articulated their ethnicity differently, what language group they were a part of. I just.. I'm very wary of getting into too much detail, because many of these are small places and it wouldn't be that difficult for someone from that community to identify who I'm speaking about and..

But I've also, I've reached out often in Alaska to people to let them know that these files exist, so that if they we're interested in trying to find records pertaining to one of their relatives, they might be able to contact the archive and see if such records exist.

And ultimately, where I've landed is that these patients— to some degree, you know— they put time and energy into making sure their experience was recorded, you know?

Like everything that I've seen— because Lantis used to work at this Arctic Health Research Center, she was, in some ways she would guide outside researchers, sometimes, through the process of conducting research in Alaska, and she was, I would say, unusually emphatic about consent procedures in those correspondences. It doesn't mean that her advice was always followed, 'cause she didn't sort

of have the power to impose anything on anyone, but I would be surprised if she was manipulative. That... it doesn't strike me as the kind of the way that she is and her relationships with her interlocutors don't look that way on paper, at least, and for what that's worth.

But yeah. I thought, you know, these patients also, like, wanted to tell their story to someone. Some of them wrote, you know, letters to Seattle newspapers about the way they were being treated in the hospital.

Some of them, you know— there's a well-known Iñupiat artist, Robert Mayokok, who actually wrote a lot about his experience in a tuberculosis hospital. His story is quite well known, at least in Alaska. I think when you start to see that, I started to reconsider and think like, "Well, people are taking the time to ensure that what happened to them is recorded somewhere."

Then, like, to not include it and have it just be a history that only ever talks about the way white people felt, just because these are sources that are mediated through a white voice and then through another white voice— my own. It still doesn't. That still doesn't seem, like, an acceptable solution either.

CHRISTOPHER BRICK: Yeah, it's not a particularly effective response to the problem that your history is trying to respond to.

TESS LANZAROTTA: But it's not something that I sit easy with or that I feel like I've finished with or resolved in any way. I mean, I'm still sort of in the process of writing a book proposal and hopefully eventually writing a book, so this is still a project that's kind of taking shape rather than fully formed.

CHRISTOPHER BRICK: Are you finding, you know, when you talked about that intermediation that is present in these sources— Are you able to get, from those sources, a sense of how these cultural differences and interchanges are mediated in the healthcare space?

TESS LANZAROTTA: Yeah, there's some very direct kind of cultural misunderstanding. So, life in a tuberculosis ward is very structured. Patients have different, kind of, grades depending on how severe their case is seen as being, and that determines what their daily routine is like and how much up time they get, how much time they're allowed to spend out of bed.

You know, one of the things that Lantis really talks about in her notes is just like how disruptive that is, especially people coming— and the majority of the patients who are being taken to Seattle are coming from the northern parts of Alaska.

CHRISTOPHER BRICK: Right.

TESS LANZAROTTA: Where life is temporarily organized very differently, especially at this

time, when still largely subsistence-based economies. It's very seasonal. There's no expectation that children go to bed at a particular time in the summer when the sun is still shining.

CHRISTOPHER BRICK: Right.

TESS LANZAROTTA: Like that's just not that... Some of our cultural expectations around how people live in time— as much as they're shaped by, kind of, industrial capitalism— are also shaped by this sort of temperate climate, and they're not... You can't just plop them into other places and expect people to adhere to them, it doesn't work. Like, there's no reason for it, so they have a really hard time. This tends to be interpreted— at least on the part of hospital staff— that Alaska Native patients, particularly Alaska Native children, are undisciplined, but you know you, sort of imagine what it must be like.

CHRISTOPHER BRICK: [Overlapping] That would be the... Yeah, the kind of paternalistic colonial perspective.

TESS LANZAROTTA: Yeah, absolutely, where they can't take that extra step of considering, like, *why* this isn't working. There's a lot of complaints about the food. In particular, Alaska Native patients don't like the food they're being offered or the foods of poor quality. It's just not what they're used to. And there's questions about the sort of salience of the education, also, that they do things like offer home economics courses using technologies that most villages in remote Alaska

would not have. That like this, these are just, it just becomes...

CHRISTOPHER BRICK: Yeah, like completely impractical contrivance.

TESS LANZAROTTA: Yeah, and the same with some of the public health education efforts that are happening during the diagnostic campaign that really emphasize these, like, ideas about isolation and bed rest and just require things of people that just don't map onto their lives in any meaningful way.

And then you see patients, you, know characterized as difficult, or recalcitrant, or resistant. And there's a sort of missing little step. But the idea that, like, the hospital has to make accommodations for patients who come from different cultures, I was actually just sort of surprised to see that be a part of the discussion in this story. So, like this is quite early, actually for them to be thinking about that.

They are, they just don't necessarily know how to do it in any meaningful way. Like they have no... Like it's... I don't think they really understand what that would look like. And that's sort of ongoing, that's been a project too of the Alaska Native corporations and of their sort of subsequent health corporations that they've started, is trying to think about ways to combine biomedicine with kind of culturally specific appropriate care in Alaska.

So most recently, in 2013, they passed the traditional foods nourishment act, which is this like really revolutionary piece of legislation that allows traditional foods— insofar as that's the right word to use— to be served in the hospital in Alaska. And that means that people donate part of their hunt, so seal, or moose.

TESS LANZAROTTA: They're restricted in the sense that, like, these are not commercialized, this kind of food is not commercialized. It can't be. There's some exceptions, but it generally can't be sold, so it has to be donated by hunters from their own catch. And this is usually community based, redistributed food. Or food that's, sort of, redistributed at a community level, so now some of it is sent to the hospital and they've had this program of teaching the hospital staff how to make these more traditional recipes.

They're being taught by elders from various communities who come in to say like, "OK, this is how you make seal soup." So that patients who are like coming in from this region can have food in the hospital that's familiar to them, and that in their mind, you know, is associated with healing for them.

Because being that it, you know, it's just.. It's a part of.. It's a gesture towards sort of making the hospital into a space that's responsive to its patients, and that isn't just a one size fits all kind of operation.

CHRISTOPHER BRICK: Well, and treating the whole patient, you know. And that sounds very cool.

TESS LANZAROTTA: Yes, yeah. And I mean the necessity of doing things like that, I think... Part of the reason it's felt to be a necessity to take these kinds of actions is because people have historical memory of these times when that didn't happen.

Where they weren't able to communicate properly with hospital staff or weren't able to keep in touch with their families on a regular basis and weren't being given food that they recognized and sometimes weren't being allowed to speak their own language.

And you know, struggling with kind of all the ways in which hospital life was attempting to [Long pause] sometimes, intentionally and sometimes unintentionally, like sever these community and kinship ties, and to experience that at the same time as you're experiencing an illness is, I mean, incredibly traumatic.

CHRISTOPHER BRICK: What do we do with this concept of biomedical progress?

You know, because I think about the last year of the framing of how this is unfolded is: "OK well, we have a novel pathogen, we have a novel virus, now Coronavirus that's *really* just disrupted so much and upended just about everything."

A lot of discontinuity, a lot of dislocation, displacement, and, of course, a lot of death and suffering. But it's been narrated too in our public discourse as triumph over the pathogen, right? Triumph over the symptom: we're marshaling resources, and expertise, and scientific knowledge to combat this— and there's some truth to that.

But there are a lot of costs, and there are a lot of challenging aspects to history of this process by which what we call biomedical progress is generated, right?

TESS LANZAROTTA: Yeah, and I mean, I think the notion of biomedical progress is a complicated one, because it depends what you look at, right? Like where do you point your lens? Because if you just look at death rates; this *is* a story about biomedical progress. This is an epidemic that is arrested and that is good!

I don't think anyone saying like "We shouldn't have done anything!" But the question comes to be, you know, when do we use, for me, these sort of narratives of progress as kind of a blunt instrument to erase all the other things that are folded into biomedicine?

So, I would say; on the one hand, this story is a useful one, also, for thinking about COVID. Because we see this sort of investment in innovation and, kind of, we have these wonder drugs. We're going to innovate, we're going to do something dramatic. You know, in many cases in American history I think this is an argument that's well known maybe to

historians of biomedicine, but not as widely to anyone else, that investment in biomedical research in the United States comes to be a stand-in for investment in, like, public health or medical primary care, more broadly.

That, like, we're going to improve medicine in the United States by improving our investment in research and improving the tools we have. And, you know, they got their COVID vaccine incredibly fast, remarkable, but the bureaucracy for delivering it. It's not there. Well, why not?

CHRISTOPHER BRICK: That's a good point.
[Overlapping] You're right, yeah, 'cause to the extent... [Unintelligible]

TESS LANZAROTTA: Like health care delivery hasn't been a sort of point of substantial intervention, in part because like, you know, nobody gets bonus points for their creation of successful bureaucracy. Everybody thinks they hate bureaucracy because you only encounter it when it's visible, and when it works well, you don't see it.

CHRISTOPHER BRICK: And a lot of times when you encounter it, I mean, it frustrates intention in some way, shape or form, right? Because it's designed to do that in many cases.

TESS LANZAROTTA: Well, and there's been some degree of, what I would call, anti-Indigenous racism in Alaska recently, where some people are upset that Alaska native people are getting the vaccine so fast. That tribal health corporations who, as we

know, have this long history of investing in and innovating in health care delivery, and in primary care, and making... and whose goal is to serve their constituents. Like to ensure that the shareholders and these corporations are getting this vaccine as fast as possible. Surprise, surprise, like they're doing a great job of that because it is genuinely their primary goal, and I think there's a real lesson to be learned about, like, who should we trust to, sort of, come up with solutions, right?

CHRISTOPHER BRICK: Well, it sounds like there's a template that's out there that's working, and thus is workable.

CHRISTOPHER BRICK: I'm certainly grateful that you made the effort because you were able to share some of its fruits with me, for which I am grateful, and I know so too our listeners are as well. So, thank you Tess Lanzarotta.

TESS LANZAROTTA: Thank you.

Conclusion

CHRISTOPHER BRICK: And that is a wrap. Please join us again next time when professor Dan Royals will lecture on the history of black America and the HIV/AIDS epidemic in the United States. We'll catch you then.