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**UNSETTLING INDIAN HEALTH SERVICES:
SECULARISM, MODERN MEDICINE, & THE REPRODUCTION
OF THE U.S. SETTLER STATE THROUGH THE 1954 TRANSFER ACT**

By

JILLIAN GRISEL

B.A., MIDDLE EASTERN STUDIES, THE UNIVERSITY OF UTAH, 2011

M.P.H., THE AMERICAN UNIVERSITY OF BEIRUT, 2014

THESIS

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Master of Arts

M.A. American Studies

The University of New Mexico

Albuquerque, New Mexico

July, 2019

Acknowledgements

Words cannot capture my gratitude for the privilege to develop my work and discuss radical ideas in a university setting. The American Studies program at the University of New Mexico has transformed my world view to trust my heart song that a new world is coming. I want to express my sincerest thanks to my advisor, Dr. Kathleen Holscher, who took me seriously as a scholar. She pushed me beyond what I thought was possible and I will forever be grateful for her patients and support in my journey to becoming an academic. I want to say thank you to my committee members, Dr. David Correia and Dr. Alyosha Goldstein, for believing in me and offering generous support through their genuine concern, criticism, and time. They all made the difference in moments of perceived failure.

I acknowledge my journey and work as an academic is not my own. Numerous communities and people have touched my heart by challenging me to think critically while taking care not to abandon hope. I want to say thank you to the Faculty of Health Sciences at the American University of Beirut where I obtained a master's in public health. There, I was mentored and mothered to think about struggles of life and death under the guidance of Lebanese, Armenian, and Palestinian women who continue to influence my life pursuits. They taught me the stakes of bringing heart felt solutions when countering the root causes of deplorable health outcomes. As a part of me now, I hope to continue their legacy of nurturing communities and the nonhuman world.

I want to say thank you to my husband, Travis James Cambridge and the Diné people. As an Indigenous man fostering a healthy masculinity, my husband has the most brilliant mind and spirit I have encountered. His commitment to cultivating peace by sincerely walking the peyote road honors his family and people. It has given him the tools to problem solve through love in the face of the most oppressive conditions. Through his daily example, he demonstrates to me what it truly means to dismantle settler and capitalistic relations. I am grateful he is my partner and shares his life with me.

I want to say thank you to my dear friend Sandra Yellowhorse. As a friend and colleague, I respect her work immensely. I want to express my gratitude to her for always motivating me in dark times. Her determination to build a better future inspires me, informs my work, and I will never forget her generosity.

Lastly, I want to say thank you to my family. I am a descendent of over seven generations of care workers. I am grateful for their sacrifices as midwives, mothers, and spiritual healers. Thank you to my mother, Christy Vanwagoner, for encouraging me to get my education so I can “do something different.” And most of all, thank you to my beloved sister Jessica Grisel. As a nurse, she has a deep understanding of the revolutionary power behind the creative practice of care work. Together, we have cried and laughed, despaired and envisioned, a future of hope through a multispecies justice. I love her and thank her for not giving up on me. I am here because of her love.

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ABSTRACT

This thesis takes up the role of secularism in modern medicine as a political doctrine that works in service of settler colonialism. I argue the *Declaration of Human Rights* and the World Health Organization (WHO) globally institutionalized secular ideologies in the post-World War II environment. This thesis links how this global reordering came to inform U.S. health policy by examining how government officials and medical experts drew from the WHO and framed infectious diseases as a security issue to impose a biomedical order in Indian country. By contextualizing modern medicine within a settler political economy and secular political doctrine, I demonstrate how the settler state reproduced itself through secularizing processes that sought to dismantle Native spirituality.

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I. Introduction

In my thesis, I examine the secular character of the 1954 Transfer Act, which moved Indian health responsibilities from the Bureau of Indian Affairs to the jurisdiction of the U.S. Surgeon General in the Public Health Services (PHS). I argue the transfer was not merely a part of national termination policies aimed at assimilating Native Americans, but an extension of a global regime that universalized biomedical knowledge and practice as set forth by the United Nations and the World Health Organization (WHO). Here I unpack the secular sensibilities and myths that were transmitted through this knowledge, came to influence national health standards, and in doing so worked in tandem with settler colonialism to reinscribe settler relations in the U.S. I propose that the health services transfer served a particular function of U.S. governance that disappeared, and continues to disappear, a continuum of settler colonial and capitalist culpability for deplorable Native American health outcomes. I seek to understand how secularism has worked with settler colonialism to establish a modern, global standard of health that has abetted that disappearing.

This thesis begins with a discussion of relevant theory related to secularism and settler colonialism. I then turn to a review of U.S. Indian healthcare, from its first deployment in 1802 until the final proposal and passing of the Transfer Act in 1954. I draw from historical, critical indigenous, environmental, public health, and medical sources to contextualize how modern medicine was a settler tool that aided in securing the U.S. political economy. I put this in conversation with federal laws issued in the late nineteenth century that sought to outlaw Native religious practices and also suppressed

their health system. I then position The Transfer Act in relation to the World Health Organization (WHO) and the creation of global health definitions that conformed to the U.N. charter of human rights. I trace the link between medical associations aligned with the WHO and midcentury developments in U.S. health policy. By first teasing out the secular myths and sensibilities that underlay WHO standards of health, I am then able to trace the secular character of those health standards extended into the U.S. context, and applied to condition Native Americans in a shifting global political economy. I do this by examining the discussion that took place in May of 1954 within the Committee on Interior and Insular Affairs, a subcommittee that met during the second session of the 83rd U.S. Congress.

Finally, I conclude my thesis by demonstrating how government officials and medical experts drew from the WHO and framed infectious diseases as a security issue to impose a biomedical order in Indian country. Because the WHO defined health as a human right only achievable through capital relations, it became the vehicle for the U.S. to intervene on reservations in the name of protecting settler society from tuberculosis – an infectious disease still prevalent among Native Americans. For medical experts, this meant secularizing Native people through modern medicine that also required suppressing their spirituality because of its entangled nature with their traditional health system. Thus, by linking the WHO's definition of health to the medical expert advice advocating for the Transfer, I illuminate how the suppression of Native spirituality – a fundamental tenant of native life and being – was at the heart of this process.

II. Theoretical Framework

For my theoretical framework, I employ Talal Asad's and Sylvia Wynter's theorizations of secularism and apply them to a settler colonial analytic. Asad's theory of secular myth and sensibilities are useful because of how he develops his reading of the secular in relation to *The Universal Declaration of Human Rights*, international law, and a global secular project of order.¹ Sylvia Wynter's theory is necessary because it demonstrates how modern sovereign powers colonized Indigenous being through secularizing processes that sought to craft a particular mode of humanity.² Both theories work together to cast light on how secularism came to be embedded in the institution of the WHO, and through that institution came to inform medical practice, mobilize state power, and extend its reaches across Indian country on the brink of globalization and development.

I also situate secularism within scholar Patrick Wolfe's theorization of settler colonialism. Wolfe articulates settler colonialism as a specific social formation that works to eliminate Indigenous people.³ Wolfe theorizes that life, in its most irreducible nature, is dependent on land, so struggles over land can be framed as struggles over life. Settler colonialism is a specific kind of colonialism premised upon land seizure and the transfer of territories that depends upon the annihilation of Indigenous population that inhabit the area. According to Wolfe, Native people living within a settler-nation therefore encounter a distinct form of life ordering related to their continued dispossession.⁴ Racial regimes comprise this order, and as a fundamental tenant that structures Anglo-European societies, work to reproduce unequal populations that expand or eliminate raced populations in service of those regimes.⁵ Other regimes that animate settler society

include hetero-patriarchy, class, and speciesism, that along with institutional forces, such as modern medicine and law, work to naturalize and enforce this life ordering.

This relation between settlement and dispossession is ongoing; Wolfe argues a settler-state must reproduce itself as a “structure and not an event” in ways that are always seeking to eliminate Native people but are not necessarily genocidal.⁶ Some of these “positive” components Wolfe refers to include the “breaking-down of Native title into alienable individual freeholds, Native citizenship, child abduction, religious conversion, resocialization in total institutions such as missions or boarding schools, and a whole range of cognate biocultural assimilations.”⁷ Wolfe’s theorization of settler colonialism is useful because he attends to the complexities of how settler society sustains itself, and provides a framework for understanding the historical transitions in U.S. Indian policy, away from frontier killing and toward assimilation, among other modern modes of elimination.⁸ In this light, Wolfe’s theory provides a guide in how to position the Indian health transfer as a settler formation amidst the institutionalizing of global secular ideologies in the post-World War II environment; one that aided in the settler state’s reproduction and naturalization.

Secularism

Over the last two decades, scholars have begun to debate secularism as a political ideology connected to global capital, nationalism, state, and empire building. Talal Asad in particular has made path-breaking interventions by theorizing “the secular” not in opposition to the religious, but as a concept articulated through institutions, ideas, and affective orientations that constitutes an important dimension of modernity today. In his

book, *Formations of the Secular: Christianity, Islam, Modernity*, Asad takes secularism as his object of study. Early on, he identifies a profane/sacred grammar that was once at home in religious rule, and that persists through the modern period in liberal human thought and western law. Secular power, in this sense, emerged during the modern era as tenants of sovereignty connected to law, property, liberty, and natural rights came to be sacralized.⁹

A modern concept of the human, as an autonomous subject, is the foundation for such secular values and characterizes secular power in a distinct way. Because a secular subject is defined as a self-owning agent, their ability to exercise their agency depends on a certain amount of liberty. This is a sacralized value associated with natural right, and as a character that marks a secular society, must always be guarded and protected by the State.¹⁰ Pinning down this logic is Asad's major theoretical intervention, because while secularism appears to advance agency as a project of individual empowerment, humans are still subject to the laws and rights defined via the nation-state. Consequently, secular investment in the human, specifically within a legal realm, inversely imbues the nation-state with power by permitting it to act in the name of those rights it defines and naturalizes as sacred.

The Myth of Human Rights

Human rights were internationally recognized as law in 1948 under *The Universal Declaration of Human Rights*. *The Declaration* states that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the

foundation of freedom, justice and peace in the world.”¹¹ Asad exposes the secular myth behind this conceptualization of rights, by first demonstrating the way in which its assertion of universal human character hinges upon a sacralization of liberty and agency under the liberal principle of “all men are created equal.”¹² He exposes this logic by stating: “To insist that manifest social inequalities and constraints were ‘unnatural’ was in effect to invoke an alternative world –a mythical world –that was ‘natural’ because in it freedom and equality prevailed.”¹³

The world, Asad points out, does not naturally conform to this mythical world conjured through the liberal concept of the human. And so it becomes cast through this myth as a dark place in constant need of redemption—a place where humanity must constantly reaffirm itself. Thus the myth of human rights, as captured in *The Declaration*, authorizes sovereign powers to invade other nations’ using military force that in turn produces violence. This presents a contradiction: because human rights is a condition for peace but not naturally occurring, violence must be inflicted repeatedly in the name of humanizing the world. As a political doctrine, secularism produces the conditions it claims to eliminate.

For Asad the myth of human rights sustains political projects that impose human order by supplying a secular redemptive logic that is seductively framed as available to all. According to Asad, “[liberal myth] must dominate the unredeemed world –if not by reason then, alas, by force –in order to survive.”¹⁴ Secularism legitimates state violence through a mythic logic that “...connect[s] an optimistic project of universal empowerment with a pessimistic account of human motivation in which inertia and incorrigibility figure prominently...”¹⁵ Secular redemptive politics in this way is distinct

from religious redemption, through which sinners are saved from a godly force outside themselves. Instead, secular redemption is a never-ending project to "humanize" the world by any means necessary, including violence, so humans can redeem themselves as a subject exercising agency. In a world of nation states, human agency is legally enshrined and interpreted by experts, so secular redemption is a system of domination, where the State is the power that facilitates the conditions for the "true human" it must sustain.¹⁶

Secular Citizenship, Governance, & Power

As mentioned, Asad theorizes that the profaning of religious authority did not indicate a break between the secular and the religious, but rather was a shift in grammar that sacralized tenants of sovereignty associated with the modern subject. This new grammar came to characterize modern modes of governance that required a political medium, one that could enable people to imagine a unifying experience that superseded tensions of difference. Asad terms this mode of subject making *transcendent mediation*, stating "in an important sense, this is secularism," because of the relationship a sovereign power has over its subjects.¹⁷ Citizenship represents this medium in the modern secular state, and as an imagined and institutionalized subjective formation limited to this world, attempts to rise above differences expressed through social constructs and reinforced by state hierarchies, including those of race, gender, and class.¹⁸

For Asad, transcendent mediation is a legal technology the secular state uses to coerce its citizens into a secular order. He theorizes this as a hegemony "linked to the

desire to stabilize the contingent character of the self through a legal concept of the person.”¹⁹ The “essence of the human” then becomes circumscribed into legal discourse as a “sovereign, self-owning agent and not merely a subject conscious of his or her own identity.”²⁰ This becomes hegemonic because in defense of a citizen’s rights, the state is authorized to “legally punish and threaten violators.”²¹ International human rights law both complicated and strengthened this dynamic, by allowing sovereign nations to act on behalf of other nation’s citizens for human rights violations. Thus, human rights law can and does enable sovereign states to act with impunity through military and police violence.

Secularism, Being, & Settler Colonialism

A settler state like the United States seeks to naturalize its political economy within the context of colonialism through secularizing processes that homogenize difference and reconstitute identity formations. While Asad theorizes this through a political medium of transcendent mediation, Jamaican scholar Sylvia Wynter deepens the analysis by describing secularism and its impact on identity as a colonial condition meant to tame bodies for labor. She posits that secularism and colonialism did not exist in a vacuum, and as sovereign powers distinguished themselves from religious rule, they “othered Indigenous people.”²² The concept of Man “de-godded as a political subject,” or in other words the secular concept of the rational governing self, was applied as a gold standard in initiatives to modernize Indigenous people.²³ Such initiatives invariably included efforts to disenchant the “primitive superstitions” of Native people in order to humanize their “lack of being.”²⁴ Colonizing Indigenous people in this sense did not just

aim to produce a malleable work force; it also insisted upon secularism as a medium for attaining humanness, and upon a secular mode of being human.

Secularism served colonialism in part by naturalizing the social hierarchies it produced through the physical and biological sciences. According to Wynter, science under secular powers reinvented Man to be what she terms “the biocentric political man.” For Wynter, the biocentric man is a concept understood through a “descriptive statement of the human on the biocentric model of a natural organism.”²⁵ According to Wynter this required a “cognition” of “objective” “observable facts” on a “physical level of reality.”²⁶ Enchanted ways of life that were spiritually guided came to signify degenerate modes of being that compromised one’s agency as a rational human and threatened the natural order defined by modern science. In colonial contexts, Protestant spirituality formed with the rise of the nation-state and physical sciences, which in the creation of political subjects, reframed Man and its relationship with nature. Western intellectuals established the material world as being composed of universal substances that discredited any kind of outside supernatural influence.²⁷ Man, as comprised of these substances, now was a rational political subject to the State. To adapt the natural world and interpret Man to any other truth was considered a lesser “mode of human” and was systematically attributed to racialized subjects, such as Indigenous people.²⁸

Wynter concludes racialization of Indigenous people, and their lifeways defined against secular science, justified their dominance into what she states “...is, as one that defines us biocentrically on the model of a natural organism, with this a priori definition serving to orient and motivate the individual and collective behaviors by means of which

our contemporary Western world-system or civilization, together with its nation-state sub-units, are stably produced and reproduced.”²⁹

Wynter’s concepts here are relevant because they demonstrate how settler colonialism reproduces itself through secular sensibilities, which come to inform settler narratives and shape colonial societies. Wynter’s attention to how a biocentric model of humanity comes to organize colonial knowledge and space speaks to Patrick Wolfe’s analysis of settler societies and the way they reproduce themselves through institutions and discourses. Wolfe argues that, as a settler society moves throughout time, it must “transmut[e] into different modalities, discourses and institutional formations.”³⁰ As the settler state readjusts according to norms and common consensus, it reproduces itself through multiple platforms that include the “positive outcomes” mentioned of “resocialization in total institutions and a whole range of cognate biocultural assimilations.”³¹

Wolfe describes the post-World War II era in the United States as a historical moment that accelerated these settler strategies. Assimilation became the prominent U.S. settler elimination logic that was naturalized through a biomedical definition of Indianness. Wolfe terms this “a blood quantum regime” that followed the extension of U.S. citizenship to Indians in 1924 and the 1934 New Deal Indian Reform Act.³² These policies admitted tribes as long as their constitution subjected and conformed to U.S. law. However, Native people became legible through a biomedical order intent on destroying the “heterodox forms of Indian group-hood.”³³ These strategies, while “reinforced by the politics of termination and relocation”, were narrated by a “biological calculus” where blood, a material substance, animated their Native being.³⁴ To assimilate, Indians needed

to be off reservations and in urban areas where liberation from the “thralldom of the tribe...” meant being a wage laborer *and* knowing themselves as a secular bio-political subject. What Wolfe implies and Wynter argues, is that the biocentric model of the human came to inhabit the center of this naturalizing process of the elimination, whereby the settler state demanded a population of “de-supernaturalized” subjects through disenchantment.³⁵ The demystification of nature and bodily functions through reason and science has long been a major tenant of the settler state. Expressed through the technical discourse of modern medicine during the twentieth century, it imposed a secular order onto Native bodies.

Modern Medicine, Pain, & Disenchantment

Modern medicine emerged as a key source of secular authority that seeks to explain pain. Because it follows a secular logic, modern medicine sacralizes human agency and denies supernatural influences and relationships. Asad argues that, under secularism, pain is understood as something that compromises agency by limiting one’s ability to act effectively in the real world. Asad posits that overcoming pain is therefore necessary to preserving the “self-ownership of the individual to whom external power always signifies a potential threat.”³⁶ This speaks to the myth of human redemption, and opens space for the institution of modern medicine to define the limits and potential for overcoming pain as a condition of a biocentric human. Asad states that as pain was dissociated, under secularism, from Christian celebrations tied to “the myth of Christ’s suffering”, discourse about pain came to be “objectified” and “sited within an accumulating knowledge of the living body.”³⁷ This allowed medical practitioners to

“approach the question of pain without introducing religious obsessions.”³⁸ Here Asad demonstrates that the secular orientation of modern medicine did not merely represent the “abandonment of a transcendental language” in the religious sense, but “the shift to a new preoccupation” where secular sensibilities of pain shifted to a state within/internal to the body observable and solvable only in the reality of this world.³⁹

The profanation of religious pain was in effect the sacralization of modern medicine, which consequently played a significant role in defining the constitution of a secular subject as a self-owning agent. According to Asad, the secular principle of eradicating pain required, and legitimated, technologies for disciplining people into being more governable in this world.⁴⁰ As Wynter has articulated, such technologies take on distinct shapes, and serve distinct purposes, among Indigenous people. Asad states that in the modern world “traditional cultures [did] not spontaneously grow or develop.”⁴¹ They were rather “pushed, seduced, coerced, or persuaded into trying to change themselves into something else, something that allow[ed] them to be redeemed.”⁴² As part of this process—which was also a process of disenchantment-- medical descriptions and discourse alienated “traditional societies” from the possibility of tapping into health systems that rely on spiritual and ancestral reserves through place specific knowledge.⁴³ Medical practice entered as a means to convert humans to being sovereign. Becoming a self-owning agent, and secular human, meant mastering pain through systematic observations that were interpreted via institutional rules that in turn privileged rationality as a guide through all processes.

In other words, transcendence in modern medicine is not dead. Under secularism one’s pain / disease experience is reconfigured through internal bodily investigation, and

measured against presumed universal human norms. These norms were developed in tandem with European colonialism, and they serve white settler society and capitalism by dislocating disease / pain from place and time, as well as contexts of relationality, to posit something solely resolvable in the body. Consequently, secularizing processes and sensibilities play a significant role in modern medicine, which in turn aides in constructing and normalizing settler dynamics. In such contexts, modern medicine can work as an apparatus of state bodily control through its secular character, which defines pain in ways that are both universalized and entangled with liberal concepts of the human. Anything that impedes human agency, such as pain and suffering, is “inimical to reason,” and erodes a secular society.⁴⁴ Secular power is then galvanized by such sensibilities around pain because it presents a "human condition that secular agency must eliminate universally."⁴⁵ For secularists, human agency can only reach its potential when void of pain, and because sovereign powers define it, the secular subject constructed. This state-crafting of self-discipline, participation, economy, and law puts into play different structures of "ambitions and fear that regulate violence through law."⁴⁶ Conceptualizations of disease and pain are part of that constellation of power that is both secular and settler.

III. Review of Indian Health Services

From its inception, U.S. medical care for Native people was a function of the military. The first documented encounter between U.S. doctors and Native Americans was in 1802, when the War Department enlisted doctors to vaccinate Native people, in order to protect soldiers from being infected by communicable diseases like smallpox.⁴⁷ The U.S. army deployed physicians to contain infectious diseases especially among tribes near military posts. In other words, Native Americans were only treated with medicine because it benefited the settler state. By 1824, the War Department had established a formal Indian health sector, and in response to large-scale epidemics, Congress authorized doctors throughout the nineteenth century to conduct mass vaccinations.⁴⁸

The military control over Native health ended in 1849, and administrative duties for Indian healthcare shifted to the Department of the Interior. This happened during a time when Native people were being assimilated in the U.S. through the treaty system and in its wake.⁴⁹ Formal healthcare relationships were established out of treaties, under which the U.S. government promised health services in exchange for Native lands and resources.⁵⁰ Such exchanges were always motivated by U.S. expansion in the service of capitalism, and accompanied U.S. efforts to diminish Indigenous autonomy through controlled food economies, agriculture, resource extraction, and forced relocations.

Elimination Logics

Settler colonialism generally interlocks with other oppressive systems, such as capitalism and resources extraction, that together dispossess Indigenous people by inflicting massive amounts of violence to the human and non-human world. The U.S. operates within these systems, and as the nation expanded during the nineteenth century, its accompanying strategies of Native dispossession included tactics of genocide, ecocide, and land grabs. Anishinaabeg scholar and activist Winona Laduke describes this time (and until the present) as a “holocaust” of destruction that has directly linked the loss of plant and animal life to the loss of material, cultural, physical, and spiritual wealth of Indigenous people.⁵¹ Scholar Roxanne Dunbar-Ortiz traces this holocaust in her book, *An Indigenous Peoples’ History of the United States*, as an extension of imperial and colonial forces that converted into settler and capitalist strategies and forced Indigenous people into compliance. For example, in the mid to late 1800’s the U.S. broke several treaties by passing the Homestead Act, Morrill Act, and the Pacific Railroad Act that took land from Native Americans and “privatized it for the market.”⁵² At this time, the military worked alongside industrial corporations to instill Indigenous economic dependency by destroying their substance economies by massacring animals essential to their survival and ways of life.⁵³

By end of the Civil War, the federal government had gained control of Native people’s food supply by the strategies mentioned, and established a food ration contract system.⁵⁴ Federal Indian agents worked with the Bureau of Indian Affairs (BIA) to control reservation food systems throughout the U.S., as part of a wider set of U.S. settler policies and tactics meant to control reservation life. The bureaucratic standardization of

food distribution was not based on nutritional value, but rather on the shelf life of the foods, and on the highest bidders among prospective suppliers. As such the meat industry came to have major influence upon the diets of Native people reliant on federal aid and agriculture.⁵⁵ Government food strategy also aligned with efforts to allot and privatize Native lands. For example, the majority of the Kiowa, Comanche and Wichita tribes in Oklahoma were instructed by state agencies and mission schools about agriculture during the 1870s, eighties and nineties, and by 1901 an allotted 160 acres were distributed to tribal members, with the remaining two million acres sold to Euro-American settlers.⁵⁶ Between the land grabs, destruction of Indigenous substance economies, gaining control over food economies, and other genocidal tactics, the U.S. military, along with industry and settler-owned mercantile businesses, sought to absorb and control Indigenous land and resources.⁵⁷

Suppression of Native Spirituality & Advancing Modern Medicine

In 1883, the Bureau of Indian Affairs issued a set of laws known as the *Indian Religious Crime Codes*.⁵⁸ These laws prohibited Native American ceremonial activity and authorized Indian agents to stop dances, feasts, and medicine men. The Commissioner of Indian Affairs, Thomas J. Morgan, later codified these laws in 1892 as the *Rules for Indian Courts*, to issue jail time for any Native person caught practicing Native religion or ceremonies on reservations.⁵⁹

While these laws meant to suppress Native spiritual acts, they also suppressed Native peoples' health systems by targeting "medicine men" for engaging in their spiritual practices.⁶⁰ Native people relied on medicine men to treat their diseases and

bodily ailments because their health practices were bound to their spirituality. According to the *Rules for Indian Courts*, medicine men misled Native people “from following civilized habits and pursuits...[that also] prevent[ed] Indians from abandoning their barbarous rites and customs.”⁶¹ These laws reflect how the settler state relied on the disenchantment of Native people as a tool not only to govern spirituality, but to instill a system of knowing the body, self, and others. Modern medicine was imposed on Native Americas as the solution to fill the caring and curing void the State intentionally created in their attempt to eliminate medicine men. Like Christian missionaries, modern medicine would serve as a resource for the settler state, providing an alternative to Indigenous being, but from a secular point of view. Such medicine brought knowledge about how to be in and move through the world as a bio-political subject.

These types of policies forced Natives to practice their religion and traditional health methods in secret while offering little to no alternative health services through the U.S. government. Official U.S. healthcare was promised in treaties, however every treaty was different and did not specify the details of what and how care would be given.⁶² By 1880, a mere seventy-seven physicians were employed to care for the entire Native American population in the U.S. territories, and the government had not appropriated funds for a single Indian health program. Physicians were hard to recruit because of low pay along with a massive disparity in resources; the government allocated a mere \$1.25 per Indian compared to \$21.91 per army soldier and \$48.10 per naval sailor.⁶³ This pattern persisted even with the first Congressional appropriation for Indian health in 1911, and the creation of a health division within the agency in 1921.⁶⁴

Natives were also not allowed to practice any kind of ceremony within the hospitals, and doctors documented this sort of suppression into the 1950's. Dr. Michael J. Pijoan wrote a statement in 1951 right before he resigned from his post in a reservation hospital:

The system is no longer medical. It is only bureaucratic. No more ceremonies are allowed in hospitals. Indians are now numbers, not people. We are machines. This is intolerable. We leave.⁶⁵

The healthcare offered to Native people through the mid-twentieth century required they not incorporate aspects of their own cultures. The U.S. granted exclusive privilege to modern medicine, and in so doing it suppressed Native traditional health ways. Even so, the system was full of neglect, and by 1954 death rates among Native people were still more than twice that of settler society due to infectious diseases. At this time, the post-World War II environment marked a shift in U.S. economies, politics, and U.S.-tribal relations that accelerated assimilating Native people into settler society. U.S. government officials foresaw the risks involved and consequently adopted a more aggressive approach towards converting Native people to utilize modern medicine. The Transfer Act would serve this purpose, and while continuing the suppression of Native spirituality, was informed by and international network on a global scale.

IV. Indigenous Resurgence in a Globalizing Secular World

When it was ratified in 1948, *The Universal Declaration of Human Rights* resonated with the oppressed worldwide by providing a platform of de-colonial possibility. As the first collective agreement among sovereign powers to outline basic rights among individual citizens, Article I crystalized the universal human subject stating, “all human beings are born free and equal in dignity and rights.”⁶⁶ Seen by many observers as moral progress defined in international law, *The Declaration’s* rhetoric ignited pan movements that trespassed beyond colonial political boundaries, like Algeria and South Africa, and unified people under race and ethnic backgrounds seeking national liberation.⁶⁷ While these global forces did influence Indigenous and Black liberation struggles in the U.S., human rights discourse also worked at cross-purposes. Within the discourse, self-determination, development, and decolonization were grouped together as the pathway to restore agency to the marginalized through an orthodoxy that shored up capitalist interests between the U.S., international organizations, and “underdeveloped” nations.⁶⁸

According to Indigenous scholar Dian Million, during this historical moment Indigenism formed “as a specifically named political identity” which she describes as an “alternative, active, and mobile set of meanings available in the midst of present globalization, mass diasporas, and multiplicity.” As a political medium of transcendent mediation, human rights had a direct impact in Indigenous resurgence. Million states:

The rise of international infrastructure of human rights law with limited but moral shaming power to intervene in Canada and U.S. domestic affairs provide[d] a forum that illuminate[d] intimate relations of family in Indian Country; it

provide[d] a space for articulating what colonialism actually [was] in Indigenous terms: a painful dismembering of families and societies.⁶⁹

The postwar era shaped Indigenous politics in relation to what Scholar Roxanne Dunbar-Ortiz articulates as a time of “decolonization and human rights inaugurated with the United Nations and adoption of its Universal Declaration of Human Rights.”⁷⁰ Consequently, human rights discourse entered public and political consciousness via the U.N. document, and in doing so also entered global social movements that shaped Indigenous struggles.⁷¹ However, this would not be the total effect, and while Indigenous people did radically challenge and resist the human rights- self-determination- development- orthodoxy, that orthodoxy would also persist as an avenue for liberal settler states to reinscribe colonial relations through recognition politics and interventionist humanitarian aid.⁷²

Human Rights: A Settler Reordering

While *The Declaration* shaped imaginaries and politics of marginalized people, it was enacted by settler states, and worked from a universalizing human character that invoked secular myths of peace and redemption. *The Declaration* states “The United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom.”⁷³ Human rights were globally sacralized, and “social progress” was rendered as “affirming...life in larger freedom” dependent upon an individual’s possession of their “equal and inalienable rights.” In this way, *The Declaration* wrote in a place for all

human beings on a global scale, where all were human enough despite their local politics. At the same time, it proposed means for their fuller human realization that were attached to particular ways of life that defined modernity and progress. *The Declaration* summoned a secular politics of redemption, one that meant to craft a secular subject through a political project of human empowerment—one of this world, made by man, and ruled by western law.

In *The Declaration*, agency and security are both at stake in the struggle for human rights. Those rights extend both to economic stability (first detailed in Article 3), and the right to health. Article 25 of the document states:

Everyone has the right to life, liberty and security of person; and Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁷⁴

Hitched to a “standard of living,” advancing human rights came to mean mobilizing people into wage labor, or extending capitalism, including among those populations seeking liberation—the colonized. “Underdeveloped” countries were promised an improved health and education status dependent on full integration into market economies.⁷⁵ However, health and wellbeing also had to be reimagined and institutionalized if formally marginalized people were to become political bodies and realize their humanity within such material conditions. Homogenizing difference in

service of a global political economy controlled by settler societies required a biocentric point of transcendent mediation to naturalize and cultivate sovereign subjects.

Settler Colonialism & The Biocentric Man

The World Health Organization (WHO) was created at the same time as *The Declaration*, and as a U.N. entity, it sought to conform international health standards to the charter. The WHO was organized in the same manner as the United Nations, with international representation comprised of government health officials from over sixty countries.⁷⁶ In its constitution, ratified in 1948, the WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁷⁷ As a “complete state,” the constitution demarcated a rights-based approach to health as “the enjoyment of the highest attainable standard of health” and the “fundamental right of every human being without distinction of race, religion, political belief, economic or social condition.” The WHO, in other words, provided a “transcendent” standard of health by which modern medicine was to measure its work, one that rose above “race, religion, political belief, economic or social condition” and that ultimately promised peace. To return to Asad, the secular myth of redemption took on new form under the WHO as the “highest attainable standard of health.” The WHO’s universal definition of health, produced among and by medical professionals from participating countries, would provide sovereign nation-states the medical conceptual grounding to fuse the biocentric human with a legal concept of a secular, self-owning agent, and to apply it on a global level.

By grounding international health standards in a rights based approach, and linking its condition to peace, the WHO constitution inflated state power. Article 2 states “in order to achieve its objective, the functions of the organization shall... act as the directing and coordinating authority on international health work.”⁷⁸ This included a number of activities spanning from research, standardizing diagnostics, cultivating international solidarity, and eradicating diseases.⁷⁹ The WHO specified that “unequal development in different countries” posed a risk for eroding international stability, stating that “in the promotion of health and control of disease, especially communicable disease, [presented] a common danger.”⁸⁰ The WHO was not attributing unequal development as the cause of disease, rather it was the solution to the places that had not embraced modernity yet. In other words, framing infectious diseases as a risk among nations inoculated sovereign powers with the authority to intervene on behalf of the “common” good both domestically and abroad.

This dynamic was amplified under Article 21, which granted the organization the authority to “adopt regulations concerning sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease.”⁸¹ Furthermore, international adherence to the WHO’s standards was expected, as set forth in Article 22: “Article 21 shall come into force for all members after due notice has been given of their adoption by the Health Assembly.”⁸² These articles, compounded with the WHO’s overall definition of health, demonstrate how a rights-based approach is only an investment in wellbeing in so far as the standard of wellbeing is attached to “peace and security ...[and] dependent upon the fullest co-operation of individuals and States.” The WHO’s definition of health held nations accountable for the wellbeing of their citizens—

a standard more powerful countries could then leverage as a point of intervention, to impose the order defined within human rights via the eradication of infectious diseases.

The language of “unequal development”, as employed by the WHO, masks the violence inflicted on oppressed peoples that both leads to disparities and cultivates the spread of infectious diseases. Such language recasts the political crisis around race and land within settler societies by suggesting deviant populations, and by focusing on infectious diseases as a security issue framed through a secular rights-based approach to health. So, while containing infectious disease appeared to be about protecting human agency, it implicitly scripted those with them as having a dangerous autonomy. Dian Million describes this pivotal moment for Indigenous peoples as an evolving matrix “reorganized and heralded by a universalism ensconced in “Rights of Man”, or human rights, [that] was not less racist but posed and practiced racialization projects differently.” A totalizing definition of human rights reformulated how race was read –through biological descriptive statements that replaced color with pathology and medical discourse. In this way, the WHO definition of health and wellbeing mandated processes of “development” that in turn required disciplining bodies in the lands Indigenous people lived. Health became a settler formation working under the guise of secular rhetoric. In applying a biocentric universal mode of being that was naturalized by the WHO, the settler state could identify and target those who lacked.

The World Health Organization’s standardization of health was the bridge that extended human rights into medical discourse. As a political resource, the WHO definition of health would be diffused through the practice of biomedicine, where it could be applied to bodies on a global level. It deflected from the structural conditions that

created deplorable health outcomes by posing biomedical treatment on individuals, in conjunction with nation-state interventions in the name of “development”, as the solution. Medical professionals in colonial nations like the United States came to read bodies through this lens, and to educate patients, and execute health practice within these parameters. Not only wealth but health too was to be realized through material conditions of markets, development and consumption. Meanwhile any spiritual / religious tenants connected to alternative ways of living continued to be relegated to private spheres, flattened out to characteristics of culture or ethnicity, and kept apart from approaches to health and healthcare. A secular definition of health was the tool needed for settler states to reproduce the conditions necessary to reshape a new global order of capital. Enforced by policy changes, this shift guided a field of action oriented around one’s personal liberty to redeem their own health, while eradicating disease through development and market economies. Secular health demanded the inclusion of marginalized people in its framework, yet it lifted their struggles of life and death from the historical context of extractive economies, forced labor, and elimination practices, and it offered instead the beneficent nation-state. A rights-based approach translated the health disparities characteristic among such people as a failure in agency– a mode of being that was destructive and threatening, and which required state intervention to remedy.

The WHO & U.S. Healthcare Policy

The World Health Organization was heavily supported by the United States. Besides providing over half of its funding, the U.S. government sent four officials from the Public Health Service to assist in its creation, including Surgeon General Thomas

Parran.⁸³ The following January, a bill entitled *The World Health Organization Bill* appeared in the U.S. Congress. It advocated for “the formal approval of the constitution of the WHO,” and argued that “its final adoption [was] urgently called for.”⁸⁴ The bill passed in July 1948, and U.S. health and medical organizations set to work to spread the World Health Organization’s message.

Healthcare professionals across the U.S. supported the WHO ratification, with both the American Medical Association (AMA) and the American Public Health Association (APHA) issuing statements of support. The APHA marked the first world health assembly as “an inspiring success,” and aimed to adopt WHO’s health program, listing six priority issues that included “malaria, maternal and child health, the control of tuberculosis, ... venereal diseases, environmental sanitation, and nutrition.”⁸⁵ The association praised the streamline and application of medical practice into formalized healthcare, stating that “substantial budget allotments... for staff and travel costs... would make possible, not only investigation of basic problems but also direct assistance to governments, at their request, in the form of expert advice, demonstration teams, and training programs.”⁸⁶ Medical professionals aimed to channel secular ideology onto bodies who now sought to unify their practice under a rights- based approach to health.

The WHO institutionalized a common census of the biocentric political body and in turn, naturalized how humans would be legible as governable rational secular subjects under settler law. Asad articulates this convergence of secular morality and law stating:

[Human rights] seem[ed] to assume a direct convergence of ‘the rule of law’ ...with social justice... [and] if that is the case, the rule called law in effect usurps the entire universe of moral discourse... [N]ot only does The Declaration

equate law with justice, it also privileges the state's norm-defining function..., thereby encouraging the thought that the authority of norms corresponds to the political force that supports them as law.⁸⁷

The WHO's definition of health as a point of transcendent mediation came to confine and define "the norms and political force" that supported the law, linking biological lack, medical discourse, and political recognition among sovereign and settler powers. Suffering and disease did not just animate the marginalized as a redemptive project, their response to it was now defined and dictated within a field of action that reproduced the relations that caused it.

This applies to Sylvia Wynter's concept of how secular being is constructed through colonial forces and Patrick Wolfe's theory of how settler colonialism reproduces itself. The WHO provided a discourse to support the secular myth of peace and human redemption, offering up secular language that bound the subjective self to the biological order. This would come to characterize a particular form of domination of the state over bio-political bodies, as an individual's biological success became tied to market integration and development.

V. The Transfer Act

Like at the World Health Organization, tuberculosis was viewed as the primary health problem in the United States among government officials and medical professionals. This was because of its perceived threat to civil order.⁸⁸ Tuberculosis, among all infectious diseases, was determined to be a security issue. In the U.S., it had been almost been eliminated except among Native Americans. Now with the economy shifting, the U.S. was faced with a dilemma because of the Termination policies aiming to integrate Native Americans into the labor force by moving them into urban areas from reservations. The U.S. economies were threatened, and the government's answer was modern medical treatment with Native spirituality being its biggest impediment.

The postwar period saw a huge shift in the U.S. economy, one that for Native communities intertwined with the effects of the Termination Act of 1953. Congress passed the Termination Act to formally end federal recognition of selected tribes, and to end federal aid and appropriate Native lands.⁸⁹ Indian healthcare in the United States changed along with these shifting forces. In 1954, The Committee on Interior and Insular Affairs met in the second session of the eighty-third U.S. Congress with the purpose of moving Indian health responsibilities from the Bureau of Indian Affairs to the Public Health Services, which fell under the jurisdiction of the Surgeon General. The minutes of the hearing unveil the U.S. government's motives for the transfer, and in doing so they speak to the secular myth of redemption, embodied as it was in the emergent discourse of rights-based healthcare, that underwrote the shift in the service of settler colonialism.

The WHO's Influence on the Transfer Act

In 1954 the shift of health responsibilities from Indian Affairs to Public Health Services was up for debate, and the Congressional Committee on Interior and Insular Affairs was the space where it would be hashed out. During these debates, all major U.S. health associations supported the transfer, including the Tuberculosis Association, the APHA, and the American Medical Association.⁹⁰ While such a transfer had been proposed many times before, it is significant how and why the Transfer Act was overwhelmingly supported at this time, and why the medical and government institutional consensus pushed so hard for its passing.

Minnesota Congressman Walter Judd had spearheaded a 1952 effort to accomplish the transfer, and during the 1954 hearings he resubmitted a statement in favor of the new bill. The transfer of Indian health services had been recommended as early as 1936, Judd explained to his colleagues, but the real momentum for it began in 1951 at the annual APHA conference. During that conference, a Committee on Administrative Practices was asked “to consider the problem of how to get better health facilities for our American Indians.”⁹¹ The action was inspired, according to Judd, by “their concern for the Indians... [and] communicable diseases in the Indian or other populations [that] are communicated to the remainder of the population.”⁹² The Committee on Administrative Practices passed a resolution recommending that the Indian Bureau hospitals and health activities be transferred to PHS, and the resolution was unanimously adopted by the Governor's Council of the APHA.⁹³ A month later the Association of State and Territorial Health Officers appointed its own committee to study the issue, and the committee concluded that there was no way to eradicate communicable diseases, specifically

tuberculosis, except by transferring the whole “problem” to PHS.⁹⁴ According to Judd’s statement, the Association of State and Territorial Health Officers followed up the recommendations made by its committee, and with the support of the APHA, it suggested the transfer.

Judd’s interest in the transfer, and his framing of Indian health as a security issue in his recounting of the history leading up to the 1954 bill, was very likely informed by the WHO’s rights-based approach to health. Judd had been elected to congress in 1942, after the bombing of Pearl Harbor, and he became one of the most influential members of the U.S. House on issues related to foreign policy.⁹⁵ As a former medical doctor, he served as a delegate to the United Nations and to the World Health Organization Assembly in 1950, and he was one of the three senators that proposed Public Law 643, or *The World Health Bill*. He was a major international actor with political clout and received credit for playing an “important role in American efforts to build stability in Europe through economic relief and development,” under the banner of his anti-communist sentiments.⁹⁶ Judd advocated coherence between the U.S. and the WHO, and now he served on the Committee of Insular Affairs with the goal to eradicate tuberculosis by focusing on Indian country.⁹⁷

Biological Transcendent Mediation, Redemption, & Order

Tuberculosis was scripted as a threat to national security and concern over it pervaded the eighty-third Congressional session. Orme Lewis, the Assistant Secretary of

the Interior, also presented the history of the proposed bill, but did so by foregrounding its urgency from a medical perspective stating:

From a strictly medical point of view, it can be stated that the major problems of health at the present time in the Indian population are infectious diseases that can be prevented and have been largely prevented in the white population for many years. The morbidity and mortality rates are at about the same level as they were for the United States in 1900 and this constitute foci of serious infection which are a threat to the total population as very large numbers of Indians migrate long distances and come in contact with white communities and citizens during the agricultural employment season. These same diseases have been of great concern to the Public Health Service and have been the subject of research and grants-in-aid by the Public Health Service to States for their control.⁹⁸

This statement reflects the assimilationist ideology of the Termination Era, during which the U.S. government would claim that as fully realized U.S. citizens, and through full integration, Native Americans would overcome their health issues.⁹⁹ However, the medical point of view that Lewis foregrounds in his statement scripts Native people as collectively lacking primarily through the prevalence of infectious diseases. According to Lewis, to achieve full integration “with white communities and citizens,” Native Americans required good health—a standard he defines in terms of the ability to labor in white society.

Lewis’s use of medical discourse trafficked secular redemption myths around health into the transfer debate. Lewis’s read of tuberculosis was one endorsed by leading medical professionals, it approached the epidemic by measuring Native people’s agency

against white society's ability to overcome infectious diseases through preventative measures. The "medical point of view" followed a secular redemptive logic that universalized Native people by implying it was available to them. The answer, according to the transfer bill, would be more medical staff, hospitals, and resources to support Native people in fully realizing themselves. However, it was now an urgent issue because of the risk it imposed to the rest of the country. In this sense, Native people could achieve human agency if they received proper healthcare.

The idea of human redemption through medical care was later expressed by Senator Watkins in a conversation with a Comanche Elder named Mr. Monetatchi. Oklahoma opposed the transfer bill, and Mr. Monetatchi was there to speak against it for his tribe. Senator Watkins attempted to persuade him in the utility of modern medicine by stating:

You people still do not have confidence in the white man, because he did not do the right thing in years gone by. I know it is a sorry story. I feel just as deeply about it as you Indians. It is a sorry story. But we are trying now to redeem the Indian and give him his real place in America.¹⁰⁰

For Senator Watkins, along with other government officials, redemption of Indians was available through medicine that linked a fully realized person to their ability to "find their place in America."

The components of redemption Senator Watkins speaks of to Mr. Monetatchi can be further illuminated when contextualized with how government officials presented Native people in the after math of World War II. Lewis opened the debate with a

“medical point of view” then followed by positioning Indian people within a globalizing world stating:

Since World War II, experience in modern communications and transportation and experience in the Armed Forces and defense plants have kindled a desire in our Indian people for better things. As a result, very large numbers are leaving the reservation, both permanently and temporarily, seeking employment. This problem will progress as the Indian population increases. Thus, for the protection of the white population, as well as the Indian population, these serious foci of infection should be cleared up not only to save lives and prevent morbidity, but to prevent future needless expenditures of Federal money at a future date.¹⁰¹

For Lewis, the modernizing impact of the war reshaped Indian people and “kindled a desire” for them to realize their humanity through employment. However, their biological being still lacked because of infectious disease, and posed a threat to settler society. Both white and Indian people relied on their redemption to save not only lives but fiscal costs. Secular subject making, at this point, was about redeeming Native Americans so they could achieve a completed human status bound to both a healthy biological body and a State order realized through market integration.

VI. Secular Medicine & Suppressing Native Spirituality

Government officials advocating for the transfer were supported by medical professionals and associations, and according to Senator Judd, there was not one medical organization that had not recommended the transfer. In one of his testimonies in the hearing Judd stated "...Medical opinion is unanimous, to the best of my knowledge. All the official agencies that have studied it, that are responsible for the health of our country, have been for it."¹⁰²

To further their argument, pro-transfer officials submitted a medical report on the Navaho and - Hopi Indians, facilitated by The American Medical Association. The report held considerable sway despite being carried out in 1948, and it advocated for Indian health responsibilities to be transferred to PHS. It was resubmitted during the 1954 hearing as evidence, with Dr. Lewis J. Moorman of Oklahoma as its primary author. Contributions to the report were expansive, with different specialists and medical professionals acknowledged in collecting data from across country. The report also included lay people from a spectrum of occupations and social positions, including nurses, ambulance drivers, missionaries, and teachers, as well as tribal councils, and Navaho and - Hopi people in general. The report had the full support of the American Medical Association, and its language reveals how modern medicine recast infectious diseases to legitimate settler society while also making the case for disenchanting Native people amidst the shifting global secular economy.

The General Report of the American Medical Association Team on the Health of the Navaho-Hopi Indians

The report began by laying out economic and educational benefits extended to the Navaho and Hopi- people through treaties. Dr. Moorman went on to explain that medical care had to date been left out, suggesting “neither of the above treaty objectives [could ever] be fully realized” without the latter.¹⁰³ While nothing could ever “redeem” the Navaho health situation, he reasoned, the major issues continuing to hinder their healthcare were social isolation, lack of development, and education.¹⁰⁴ In this sense, the doctor acknowledged wider forces associated with forced relocations, that which resulted in neglect of development, education, and health, but he presented the root of the problem as being “tucked away from civilization.”¹⁰⁵ For Moorman, civilization needed to be “brought” to Native people living in reservations, and that included healthcare.¹⁰⁶

Tuberculosis had already been identified by government officials as a security threat, and Moorman again centered Indian health as the means to keeping peace and order. In his report modern medicine rescripts the Native body as a secular project dependent for its success upon the conditions of development and education. Moorman states:

On 18 million acres of the world's proving ground erosion, the Navahos are still tucked away from civilization with two and a half square miles for each hogan. Many of them are isolated by the absence of roads and periodically cut off by sand blows, flash floods, snowstorms, and mudholes and often by the mere penalty of dire remoteness. Ultimately this remoteness caused the Government to realize that the Navaho child must be located and transported to a schoolhouse or

the schoolhouse brought to him before he can be educated... The Government in approximately 80 years, has provided schools for only 8,000 children and after all this time only 20 percent of the Navahos speak English. Economic rehabilitation has suffered the same fate. Because of a tardy consciousness of medical needs, the Indians' health has fared no better than education and economic competency. In fact, the incidence of some preventable diseases such as tuberculosis and venereal diseases, is increasing. Vaccination against smallpox and typhoid fever has proved a great boon. This is not intended as an indictment of the administration of Indian affairs but a brief enumeration of some of the past and present difficulties, including the almost insurmountable physical handicaps.¹⁰⁷

While touching upon historical harms that included “insurmountable physical handicaps,” Moorman never “indicted” colonization, but rather attributed the root of health problems to a lack within Native people that required outside intervention of development, education, and health.

Sacralizing Modern Medicine

Health discourse became not only a medium for justifying the U.S. settler state's capitalist expansion into Indian country, but also the means to position Native people as a secular project of subject making. Moorman's discourse did more than posit development as the solution to remedy poor health outcomes. It framed the argument for how disease among Native people would be eradicated through medical expert opinion that justified the dismantling of Native spirituality.

After presenting data on the interdependency between adequate education, economic development, and health, Moorman turned to a biblical example to explain Native people's health outcomes:

It may be said, as of God's command to Abraham, the United States Government has put the Navaho people "to the test" even to the sacrifice of their sons. No doubt there has been many a red-skinned Hagar praying in the desert with her "child under a bush," as in Beersheba, "when the water in the skin was done." When Abraham (many fathers) and his family followed their flocks out of Chaldea, Ur, into Canaan they could not have been more remote than the Navahos were when they were placed on the present reservation. Yet the Lord said unto Abraham, "I will bless them that bless thee, and curse them that curseth thee. From a medical standpoint it is time to claim the blessing, otherwise we may face retribution."¹⁰⁸

One might assume that Moorman sought to invoke a Christian sensibility by using a biblical story to illustrate the deplorable health conditions among Native Americans. However, by placing the U.S. government in the position of God, and the Native people in that of Abraham, his analogy in fact sacralized modern medicine as "the blessing" by which Native people will realize their humanity. Moorman may well have been a Christian, but he spoke in his report from a "medical standpoint" where the "blessings" to be extended are of this world, and not of a spiritual nature. He sacralized medicine as a secular authority. In doing so he furthered a U.S. interest in creating secular subjects, and by extension an economy that would thrive via the eradication of infectious diseases.

Secularizing the Native

According to Moorman, Native spirituality was probably the greatest obstacle the U.S. settler state faced in assimilating Native people in the name of “eradicating disease.”

In the report Moorman states:

Among the innate psychological and spiritual obstacles are the profound attachment of the Navahos to their mother earth which in their opinion gave birth and ultimate haven to not only their gods but to them and their children as well. Of equal importance is the fact that their religion is their medicine and vice versa, making their medicine men the exponents of both. Naturally, it is difficult to move them off their beloved land and even more difficult to induce the illiterate (non-English speaking 80 percent of the Navahos) to discard their native medicine (religion) in favor of the white man's medicine.¹⁰⁹

It is clear that Moorman was aware of the “enchanted” paradigm through which Navajo people saw their world, one that linked them to the land they inhabited. Working within a settler logic, Moorman realized that, because of this, moving them “off their beloved land” would be “difficult.” Thus he gestures towards bringing civilization to the Navahos, not because it was the sole answer, but would help them to “discard their native medicine (religion) in favor of the white man's medicine.” Moorman knew that more needed to be done because education and simply offering healthcare would not guarantee a true conversion to “white man’s medicine.” His next move was to single out “medicine men” as being problematic “exponents” of both. Unless the Navajos were educated as English speakers, they would never truly become the subjects—sufficiently disenchanting, and sufficiently healthy-- the U.S. settler state needed.

As part of his report, Moorman utilized medical technical language that also sought to disenchant elements of Navajo life:

Though we question the efficacy of the medicine man's way of employing a few herbs and singing, dancing and drumming the evil spirits away, we must admit that compared to the methods of modern medicine the constant presence of the medicine man and his untiring ceremonial devotions for days and nights have a profound psychological influence.¹¹⁰

Because Moorman's own worldview was based on the biocentric man, he attributed the value and attachment Navajo's had for their health system to the "constant presence of the medicine man" and its "profound psychological influence." By terming the medicine man's influence "psychological"—in other words, by translating it into biomedical discourse-- the doctor sought to disenchant Navajo lives and relationships, and to preclude the possibility that Navajo health is improved by their spiritual connection to land, or "mother earth." In this way, disenchanted—and disenchanting-- medical discourse, like that employed by Moorman in his report, suppressed Native spirituality even as it sought to articulate—and to set guidelines for—"healthy" secular subjects.

Finally, Moorman revealed a set of statistical data regarding tuberculosis, indicating the mortality rate from the diseases among Native people was approximately ten times that of the general U.S. population. Universalizing Native Americans through a biocentric lens, Moorman compared them to white people:

It may be said that the diseases afflicting the Navaho-Hopi Indians with few exceptions differ from those found in the white population only in degree and that

this difference is due to environmental conditions, want of education, and adequate medical care rather than to innate racial factors and influences.¹¹¹

Here Moorman invoked a secular myth of redemption: that because tuberculosis is merely an internal state, Native Americans can overcome it with the proper resources—their “innate racial factors and influences” would not hold them back. This myth enabled him to dislocate the spatial and historical dynamics that contributed to the spread of tuberculosis. For Moorman, Indian people required the means to know themselves in relation to a biological order translated through secular health, and modern medicine provided that framework. The implication here is that Indian people might redeem themselves through their personal autonomy, to become what the settler society needs.

VII. Conclusion

Congress officially created Indian Health Services as part of the U.S. Public Health Services in 1954. For government and mainstream medical scholarship, the Transfer Act was viewed as a triumphant moment for Native health and for U.S.-tribal relations.¹¹² The act is often considered the beginning of a modern health care network, and most health professionals and state agencies claim Native health has improved with the advent of this network, despite the prevalence of chronic diseases.¹¹³ Today IHS is the highest employer in Indian Country, and falls under the jurisdiction of tribal sovereignty. However, IHS also remains a settler institution, and as such it employs and naturalizes a settler logic that conceals links between land, life, and logics of elimination. Many in the social sciences and within Native communities today point to the historical lack of funding of IHS as a problem to be remedied by more resources, to increase access to care.¹¹⁴ Many tribal leaders argue the system is “starved, not broken.”¹¹⁵ While a lack of resources is an issue, focusing solely on this aspect within IHS naturalizes the institution rather than addressing it for what it is— a structure to bolster settler life.

This thesis traces modern medicine as a settler colonial tool from its first deployment by the U.S. military among Native people in 1802 to the passing of the Transfer Act in 1954. By contextualizing modern medicine's use among Native Americans within a settler political economy and secular political doctrine, I demonstrated continuity in how the settler state reproduces itself through secularizing processes that seek to dismantle Native spirituality. By drawing from Talal Asad's and Sylvia's Wynter's theorizations of secularism, I traced its role in a global reordering that impacted Native American health policy meant to integrate Native people into wage

labor. The WHO adopted a rights-based approach to health as an ideology that embedded health standards with sacralized secular tenants grounded in myth and violence. As Asad theorizes, by investing in human rights, as linked to natural rights, and inscribing them into international law, sovereign powers claimed new authority to inflict violence in the name of protecting those rights. This process, I posit, in turn came to inform the WHO. At the same moment, the Congressional debates that propelled the passage of the Transfer Act, dislocated accumulated health insults from the historical violence inflicted by settler colonialism and other interlocking systems of oppression. Secularism held these maneuvers together, as Asad articulates, in the shadows, and ironically lives a ghostly presence that haunts daily life and all social relations. Without reducing IHS and its work within an oppressor-victim binary narrative, this thesis is an attempt to make clear how a secular global health order, formalized with the World Health Organization during the post-World War II era, came to shape a U.S. medical discourse that reproduced settler relations through the twentieth century.

Indigenous scholars and activists have struggled, and continue to struggle, to counter the effects of settler colonial structures that include IHS. Furthermore, Indigenous people—scholars, elders, teenagers, tribal leaders, and so many other interrelated groups—address food sovereignty, extractivism, and illness/wellness in ways that refuse to create Native peoples and lands as (only) victims. Moving health under the jurisdiction to Tribal Sovereignty under Public Law 63, along with the American Indian Religious Freedom Act, was a resurgence tool for many tribes to openly integrate traditional spiritual practices within their health system.

Many facilities now operate under tribal sovereignty in Indian Country and integrate culturally appropriate health programs grounded in Indigenous spirituality. While these projects do work under the umbrella of U.S. law, they do exercise their religious freedoms to infuse traditional medicines with health care. These programs get their funding through the government, and the metrics that set the terms for the funding are still constrained within biomedical statistics and medical discourse that flatten cultural and spirituality to social categories that appear to not challenge the system at large. However, they do present sights of inquiry of Indigenous resistance and resurgence that may not be legible to secular medicine nor western law. These points of inquiry also speak to the failure of the settler-state in how Native spiritual practices have remained intact despite attempts to suppress it through elimination logics and direct genocide.

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