The Montreal Chinese Hospital, 1918-1982

A case study of an ethnic institution

by

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In fulfillment of a Master of Arts thesis
Department of Sociology. McGill University.
1983

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A Thesis Submitted To The Faculty Of Graduate Studies And Research In Partial Fulfillment Of The Requirement For The Degree of Master of Arts

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ABSTRACT

This thesis uses an open systems approach to formal organization to analyse the evolution of the organizational goals and structures of an ethnic, chronic care hospital in Montreal, Quebec, Canada. The history of the Montreal Chinese Hospital (MCH) from 1918 to 1982 has been influenced by the changing composition of the Montreal Chinese community, the development of medical technology, the shifting attitude toward and demand for, western medicine among Chinese immigrants, and the evolving ideology and organizational emphases of the health care system.

Political, cultural, and social changes have threatened the continuity and autonomy of the ethnic health care institution. It has shifted its role from a church dependent institution (1918-1965) to a non-sectarian, state dependent one (1965-1972), then to a public hospital (after 1972). These adaptations have generated different meanings and roles for the institution in the Canadian context.

The MCH's organizational goals, and structures have been largely determined by the ideology and legislation of the local host community. Few ethnic cultural elements have

been able to permeate its boundaries. Thus, the existence of the hospital was secured at the expense of some of the needs of its Chinese elderly patients. This study questions the limits of multiculturalism as espoused by the Canadian federal and Quebec provincial governments when the principle intersects with actual health care policies.

Résumé

Cette thèse utilise l'approche dite de système ouvert dans l'étude d'une organisation formelle. Elle analyse l'évolution des objectifs organisationnels et des structures d'un hôpital pour malades chroniques en milieu ethnique à Montréal (Québec, Canada). L'histoire de l'Hôpital chinois de Montréal de 1918 à 1982 a été marquée par la composition changeante de la communauté chinoise de Montréal, par le développement de la technologie en médecine, par les changements d'attitude des immigrants chinois à l'endroit de la médecine occidentale, de même que par l'évolution de facteurs idéologiques et organisationnels au sein du système de santé public.

Des changements politiques, culturels et sociaux ont mis en danger la survie de même que l'autonomie de l'hôpital ethnique. Au fil des événements, le rôle de l'hôpital s'est donc modifié: une institution dépendante de l'Eglise (1918-1965), ensuite un hôpital non sectaire dépendant de l'Etat (1965-1972), pour devenir finalement un hôpital public après 1972. Ces adaptations successives ont généré une série de définitions et de rôles différents pour

l'institution dans le contexte canadien.

Les objectifs organisationnels de même que les structures de l'Hôpital chinois de Montréal ont été largement déterminés par l'idéologie dominante et par la législation en vigueur dans la communauté d'accueil. Très peu d'éléments culturels propres à la communauté ethnique chinoise semblent avoir influencé son évolution. Aussi, l'existence de l'Hôpital chinois de Montréal a été assurée au prix de certains des besoins des patients chinois âgés. La présente étude souligne les limites du multiculturalisme tel véhiculé par les gouvernements Canadien et Québécois, quand son principe entre en conflit avec des politiques de santé en vigueur.

DEDICATION

In Loving Memory Of

Professor David Solomon

My Former Thesis Supervisor

Who Inspired Me To Search For The Meaning Of

Sociology In Reality

Professor Solomon Passed Away In Summer 1981 Just As I

Was Beginning This Study

* * *

For Tim Elijah

Our First Baby

Who Reveals To Me The Meaning Of

Life In Nature

Elijah Was Born In Summer 1983 Just As I

Was Completing The First Draft

ACKNOWLEDGEMENTS

"When I consider your heavens, the work of your finger, the moon and the stars, which you have set in place, what is man that you are mindful of him, the son of man that you care for him?...My soul thirsts for you. I have seen you in the sanctuary and beheld your power and your glory. My lips will glorify you." (Psalm 8:3-4; 63:1-3)

It is difficult to identify all the help that contributed to this research. I owe much to my wife, Evia Hoo-Chiag, who typed this thesis, managed the home, delivered our first baby, gave endless support, beared and forgave my numerous faults.

I am indebted to my thesis committee, Prof. Joseph Lella, Prof. Prue Rains, and Prof. Mort Weinfeld. I wish to express my most sincere gratitude to Prof. Lella for his endless patience with my English and for his conceptual guidance. Prof. Weinfeld, this thesis would not have been possible without his patient advice and support, particularly on ethnic perspectives. Prof. Rains, for her advice on methods. Prof. Tina Beranbaum read and commented on the first chapter. I also remember Prof. Charles Cappell

and Prof. Tony Marley for their sensitive and responsive teaching and guidance at McGill.

Fellow graduate students, in particular, Dorothy Pawluch-Gagne, an admirable friend and a supporter, has reminded me numerous of my mistakes at different stages during the process. I must thank her for her kind assistance. Daniele Champoux translated the abstract into French. Cathy Lyman and Maureen Kelly, among others, provided an environment at McGill which stimulates graduate studies. Ann-Marie and Patty Boldwin have edited part of the earlier version. John Gillmore, he edited my final draft. I would never forget all these Canadian friendships. The most crucial thanks are due to the large number of individuals whom I have interviewed. I express my deepest respect for the time, energy, and feeling they have contributed to this study. I will always treasure their lessons of human life. Any errors in this study are my responsibility.

The financial assistance of the Migration and Multi-culturalism Quebec Project (Department of Education: F.C.A.C. Program directed by Prof. Eli Locker), and the support from the Department of Sociology at McGill through Fships and summer money are gratefully acknowledged.

E.H. before Christmas, 1983

ABBREVIATION

C.I.H.S.W.	Commission of Inquiry On Health And Social Welfare
MCH	Montreal Chinese Hospital
Q.S.P.	Quebec Sessional Papers

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CHAPTER 1 THEORY AND METHOD

INTRODUCTION

The study of hospitals and health care systems in Canada has produced a rich body of literature but little attention has been paid to the history and role of ethnic hospitals. This thesis uses an open systems approach to analyse the social history of an ethnic, chronic-care hospital in Montreal, Quebec, Canada: The Montreal Chinese Hospital (MCH). In this chapter, I first outline the main themes of the study. Second, I briefly sketch the history of the MCH. Third, I elaborate the open systems perspective. Fourth, I relate this perspective to the sociological literature on hospital studies. Finally, I describe the methods I used and some research problems I encountered.

MAIN THEMES

This thesis examines how organizational goals and structures of the MCH evolved from 1918 to 1982 as it was influenced by the changing composition of the Montreal Chinese community, the development of medical technology and the shifting attitude toward and demand for western medicine

among Chinese immigrants, and the evolving ideology and organizational emphases of the Canadian and Quebec health care system. The thesis especially highlights the effects of the gradually increasing centralization of the health care system in Quebec and of the increasing sophistication in medical technology.

This thesis also focuses on the role of ethnic health care institutions in the Canadian context, examining the extent to which the hospital fulfills the ideology of multiculturalism as espoused by the Canadian federal and Quebec provincial governments. (1) Studying an institution like the MCH allows one to scrutinize the extent to which government rhetoric on multiculturalism is matched by specific policies. Ethnic communities depend largely on the vitality and strength of their communal institutions (Breton 1964; Glazer 1976), since these institutions mediate the relationship between the individuals and the larger society. One would expect institutions, such as the MCH, to both reflect to some extent the cultures they serve and to have control residing within the ethnic community. On both counts, the unfolding social history of the MCH reveals a dilution of ethnicity. In Gordon's (1964) terms, the hospital organization has been subject to both cultural and structural assimilation. (2)

One may justly question whether there are limits, in a modern liberal democratic society, to meaningful cultural pluralism. Tocqueville (1954) long ago argued that in a pluralistic political system, the solidarity of social units of local communities and volunteer associations can create new and autonomous centers of power by disseminating ideas and creating consensus among the members. Thus, they may compete with and limit the central, state power. In the case of the MCH, a series of factors have conspired to limit these processes. They include generational transformations within the Chinese community, the secularization and modernization of the health care system, and the expansion of the public sector in the health field at the expense of the private sector particularly after the Second World War in Quebec.

The factors which have limited the achievement of multiculturalism have simultaneously limited the achievement of analogous goals in the organization of health care--decentralization and community control--at least as far as the Chinese community is concerned. Bill 65 and other Quebec legislation embody these as desiderata in the organization of hospitals and other health and social service institutions. While the government intends to coordinate health care and social services across the province, it also has committed itself to adapting these

services to the problems and perceptions of those receiving them. The gradual cultural and structural assimilation of the MCH illustrates factors which limit both multiculturalism and decentralization on the one hand, and community control in the health care area on the other.

A BRIEF HISTORY OF THE MCH

The history of the MCH can be described in three distinct phases: (1) the establishment and development of the hospital before 1945; (2) the crisis and new hospital period after the Second World War; and (3) the period after 1970. A historical, socio-political examination of the Chinese community in Montreal before 1945 reveals an economically, politically, and socially under-developed group left to develop its own health care. This was due to the anti-oriental sentiment and poorly organized health services in the local community. The only outside help came from the Catholic church, which had a long tradition of caring for the poor and sick of the province. This affiliation with the church provided the conduit through which western medical technology and manpower were channelled into the hospital. Financially, however the hospital was self-sufficient: all funds for its support were raised with the Chinese community.

Even after the hospital was founded in 1918, the majority of Chinese remained skeptical of western medicine and continued to practice traditional herbal medicine. The hospital was regarded not as a place of healing but as a last resort and asylum for the dying. Further, since most Chinese regarded themselves as temporary sojourners in a foreign land, they did not donate much money or volunteer much time to transform this feeble institution into a viable hospital.

After the Second World War, the atmosphere was more favourable to the hospital. Diplomatic relations were established between China and Canada in 1944 and the philosophy of multiculturalism and individual freedom emerged as keynotes of a developing Canadian national consciousness. This gave Canada an increased capacity to accommodate Chinese as well as other minority ethnic, cultural, and political groups. Strains between the Chinese and the larger community were not as pronounced.

The abandonment by the federal government of the exclusive Chinese Immigrant Acts, the rise of second-generation, Canadian-born Chinese, and the rise of the Chinese communist party in mainland China, undermined the simple dual-class society of shop owners and their workers in Montreal's Chinatown. A new generation emerged

among the Chinese elite. This elite eventually took over the hospital as the institution was failing to adapt to abrupt changes in the rapidly progressing provincial health care system in the early 1960s. Pressure from the city's health unit either to close or update the HCH had been intense. Nevertheless, the shortage of chronic beds in the city, the number of ethnic patients in the hospital, a high proportion of elderly Chinese in the population, and the rapid increase of new immigrants--aided by lobbying from the Catholic church and a French legal advisor--legitimized the continuity of the hospital. The new elites allied with some western administrators took control and tried to modernize the hospital--this ensured its survival.

The new hospital administrators, in collaboration with the new generation Chinese elite and the French Catholic church, had strong intentions of developing the HCH's acute care functions. But they were partially blocked by the provincial government, which wanted the hospital to retain its role as a chronic care institution while the new provincial health care system emerged. Thus the hospital's development was consistent neither with the government's expectations nor with its own elites' wishes.

Although western medicine had become widely accepted among Chinese immigrants after the Second World War, they

stayed away from the primitive, technologically underdeveloped, and marginal MCH. Many of the more affluent Chinese immigrants used the more prestigious local hospitals, even when there was a language problem. The centralization of the province's health care system and stress on chronic care weakened the relationship between the MCH and the evolving oriental community, and eroded the autonomy of the hospital. The hospital continued to exist but at the expense of its integration with the community.

The emphasis on nationalism in Quebec during and after the Quiet Revolution of the 1960s caused a number of strains between the ethnic groups and French Quebec society. A perceived tendency of Chinese to leave Quebec for the other provinces caused intense concern over the fate of Chinatown. Increasing centralization of health care under Bill 65 linked to heightened Quebec nationalism resulted in the further erosion of power at the MCH away from the new Chinese elite and toward provincial health technocrats. The MCH was officially designated a chronic convalescent hospital in 1973, against the wishes of its board of directors. In order to survive and continue to attract resources from the government, the hospital submitted to this role and because of the lack of qualified Chinese personnel, the hospital employed an overwhelmingly francophone staff. As a result, Chinese staff and patients

felt exploited, and at the mercy of the westerners.

This change enhanced the hospital's alienation from the Chinese community. It was again a "dumping ground" for elderly Chinese who could not be looked after at home. Thus, the hospital lost support in the more affluent and westernized ethnic community. After a circuitous 65 years history, the MCH in 1982 found itself serving the same function it did at its birth--a place for the dying elderly.

OPEN SYSTEMS PERSPECTIVE (3)

The open systems approach to the study of formal organizations on which this study is based, is universally applicable. (4) As a sociological perspective, it has both structural and processual components. It assumes that everything is interrelated and interdependent in the empirical world. Any human, social, economic, political, or technical phenomenon can be conceptualized within its framework. It views hospitals, and other formal organizations as influenced by, and linked to, systems of the larger society. Organizations are "open" because they are in constant interaction with the broader social system of which they are a part. (5) Buckley (1967, 50) notes that for a system to be open means:

> not simply that it engages in interchanges with the environment, but that this interchange is an essential factor underlying the system's viability, and its ability to change.

Formal organizations are formed in reponse to external social demands. Their participants' positions are relatively stable and relations among participants are relatively fixed, irrespective of the individuals occupying the position (Scott 1981). They reveal patterned behaviors, norms, attitudes, ideologies, and values, and are oriented toward more or less explicitly conceived common goals. They generally pursue goals by accomplishing tasks on three levels: (6)

The institutional level determines long-term policies and explicit relations with the relevent external society. It appraises conflicting interests and obtains social and often financial, labour, and technological support for the continuity of the organization. Such tasks are often performed by a board of directors and other elite organizers and/or representatives of the organization.

The managerial level deals with and coordinates the division of labour within the organization and directs internal allocation of resources. Such tasks are often carried out by the executives and middle management of the organization.

The basic task level fulfills the organization's explicit goals, its basic raison detre is meeting the primary demands of the community. Such tasks are normally performed by technically "trained" personnel of the organization.

In order for organizations to meet demands, attain their goals, and reap benefits (whether financial or political), they require the input of various skills and resources. At the same time they must perform ideological tasks to demonstrate how their activities conform to the expectations of those who make the demands.

Technology defines the possibilities for, and limits to the ways in which, people can be organized to accomplish given tasks. (7) Competition to fulfill demands also helps to determine the ways in which an organization pursues its goals. In relation to competition, organizations must review their performance periodically to identify changing needs and to adapt accordingly. (8)

Organizational elites conceptualize and optimize their relationships with the relevant environment and enter into continual negotiative processes for the resources which their organizations need. In return, they produce services or goods which the social environment or a part of it demands. For organizations to pursue operational goals, they

may continually assess and occasionally redefine their interests, determining at what level they will exchange with the environment. Thompson and McEwen (1969) put it this way: setting of goals is essentially a problem of definition of desired relationships which are already partially on the way of being actualized between an organization and its environment. The definition of goals is never definitive, and is part of a continuous process of definition and negotiation. In fact, as Hasenfed (1978) observed, organizations are constantly confronting multiple expectations and conflicting demands in a pluralistic society. Hence the participation and shifting coalitions of powerful members in organizations play important roles for balancing those contradictory purposes.

Negotiation with the environment is not limited to the establishment of goals. It influences equally the internal structures and goal-oriented behaviors in the organization. Stinchcombe (1965) formulated the dependence as follows: "the organizations formed at anytime must obtain the resources essential for their purpose by the device developed at the time. Since the device is different, the structure formed is also different." Essentially, a hospital, to survive, must conform to institutional rules set by the larger system (e.g., the community in which it resides) which defines its credentials, patient selection

categories, proper technology, and appropriate facilities.

In sum, formal organizations are formed in response to social demand; they are fundamentally instruments for attaining goals; they are highly dependent on resources controlled by the environment. The continual negotiation with the relevent external environment influences the definition of goals, their operationalization, implementation, and all aspects of life in the organization. It is a complex phenomenon of accomodation and integration among different subgroups and of continous interaction with the environment. Hence, actual organizational life invariably reveals divergences from defined procedures (Lella 1969). (9)

This thesis addresses three fundamental questions about the interaction between environment and organization:

1) What are the major organizational goals and internal structures which have characterized the MCH in identifiable periods since its founding?

2) How have external factors influenced its stablility and change over time?

3) What does this analysis tell us about the possibilities

for cultural pluralism--that is for decentralization and ethnic/local community control in health care?

RELEVANT LITERATURE

The open system approach used in this thesis is consistent with current thinking in the sociology of formal organizations and of hospitals. It views these not so much as closed or independent units generated by entrepreneurs or elites, but as open units in complex and continuous interchange with many aspects of the environment, the very existence of which is dependent upon other systems in the environment (Scott 1981). (10)

As I noted above, little attention has been paid to the development of hospitals in ethnic communities in Canada or the United States. Hall (1958) and Solomon (1961) have shown that the ethnic and religious affiliations of certain Unites States community hospitals affect recruitment patterns of physicians; this in turn affect the careers of the physicians who serve in them.

There has also been little historical sociological analysis of the evolution of hospitals in interaction

with their environments, particularly stressing their ethnic dimensions. Perrow's (1963) classic study constitutes a point of reference for my thesis. Perrow showed that hospital goals and powerful elites change in response to changing technology and other environmental factors. As the environment demanded first community relations, then technical skills, and then coordination, hospitals characteristically made the fulfillment of these demands their goals. This enabled different elites--first philanthropists, then physicians, then administrators--to emerge as powers.

Perrow also noted that many factors can intervene, to alter, block, or reverse this process. In this study I examine the extent to which Chinese ethnicity and the hospital's involvement in a gradually more centralized health care system, have produced different patterns of goal change and change of power within the organization than those described by Perrow as these are expressed on institutional, managerial, and basic task levels of the hospital.

METHOD

Both historians and sociologists are concerned with the life of man. The former look at the uniqueness of

concrete events as they actually occur in time and space. The latter attempt to discover natural laws in order to generalize about human nature and society, irrespective of time and space. Thus Park and Burgess (1924,8) wrote,

> As soon as historians seek to take events out of their historial setting, that is to say, out of their time and space relations, in order to compare them and classify them; as soon as historians begin to emphasize the topical and representative rather than the unique character of events, history ceases to be history and becomes sociology.

I have written about one historical process but attempted to derive insights and hypotheses which "emphasize the topical and representative".

Becker and Geer (1957), Becker et al (1967), Glaser and Strauss (1967), and Lofland (1971) have suggested that on-going structural conditions, norms, processes, systems, consequences, and, in particular, attitudes, behavior, activities, and events are best studied by using qualitative methods. In order to have a comprehensive perspective, and to identify meaningful patterns in the ongoing organizational process in the naturally occuring ethnic-hospital setting, I used three sorts of qualitative methods:

1) Participant observation: Between January 1981 and

September 1983, I collected field notes at the hospital. On average, I visited once a week during the first year. In the following two years I visited about once a month to clearify problems such as the hospital census. The hospital administration provided me with a small "independent research office" during the first summer. I recorded my observations of the daily routine and relationships between staff and patients. I also engaged in casual conversation with past and present staff and patients at the hospital, and made notes of these conversation.

2) In-depth interviews: From January 1981 to September 1983, I used semi-structured questions to interview the hospital's present and past chief executives, staff, main organizers, community leaders, Chinese physicians, traditional Chinese herbal practitioners, businessmen, social workers, ex-laundrymen, second and third generation Canadian-born Chinese and others in the Montreal Chinese community. Most of the Chinatown interviews were conducted in different Chinese dialects (e.g., Cantonese and Mandarin) while English was used for occidental interviewees. These interviews yielded both historical base-line information about the development of the hospital and provided me with insight as to the perspectives of the various individuals and groups who were in one way or another involved with it.

3. Social-historical records: I examined documentary data such as the province's historical health records, the federal census, the hospital's annual reports, statistics, old Chinese and Catholic church publications, and newspapers to confirm the reliability and consistancy of data obtained through my observations and interviews, and to enlarge upon them.

Research Problems

In conducting this research I was faced with two problems. First, not all government documents were available in English. Notably, many Quebec government publications were in French only. I was forced to select and translate those documents I considered crucial to the study. This proved time-consuming and tedious, since my knowledge of French is less adequate than that of English and Chinese.

Second, hospital records were incomplete. Prior to 1965, some records were fragmentary or non-existent. I relied heavily on other historical materials and on interviews. Further, information on the Chinese community before the Second World War was difficult to collect. Fragments were available in old newspapers. Only a few elderly Chinese Montrealers were living and available for interviews. Despite these gaps, I have pieced together what

I believe is as accurate and consistent a history as is possible under the circumstances.

CHAPTER 2 THE SOCIAL SETTING AT THE TIME OF FOUNDING

INTRODUCTION

This chapter provides a brief historical description of those elements of the social context which help us understand the founding and early evolution of the MCH. First I place the Chinese in the Canadian context by looking at the historical roots of their minority status and of the legislation aimed at them. Second I look at the beginnings of the Montreal Chinese community, discussing its relations with the Catholic church, its social organizations, and attitudes toward health. Third, I look at the status, organization, and development of public health: health care organization and medical technology in Montreal. All of these factors were to play an important part in stimulating the hospital's founding and in shaping its early evolution.

THE CHINESE IN THE CANADIAN CONTEXT

Historical Roots Of Minority Status

Before the victory of the Communist Party in China in 1949, many Chinese immigrants did not regard North America

as their permanent or even second homeland. As described by Lyman (1977),

> Rather they sought the overseas areas as places where, because of accidents of opportunity, a chance was offered to enhance their status when they returned to China. A trip abroad, a few years of work in a foreign land, and a stoic acceptance of the alien land's prejudices and discrimination could, with luck, earn a Chinese sufficient wealth to return to his village in splendor (Lyman 1977, 13).

That was the dream of most Chinese living in Canada. The 1940 Canadian census revealed that less than six percent of the Chinese living in Canada were willing to become Canadians citizens (Stanislaw 1958).

In this study I use Hagley and Harris's (1958, 10) definition of <u>minority</u>:

1) Minorities are subordinate segments of complex state societies;
2) Minorities have special physical or cultural traits which are held in low esteem by the dominant segments of the society;
3) Minorities are self-conscious units bound together by the special traits which their members share and by the special disabilities which these bring;
4) membership in a minority is transmitted by a rule of descent which is capable of affiliating succeeding

generations even in the absence of readily apparent special cultural or physical traits;

5) Minority peoples, by choice or necessity, tend to marry within the group.

The history of the Chinese' migration and settlement in Canada as well as early legislation concerning them depicts vividly major elements of the above characteristics.

The first documented evidence of Chinese in Canada refers to 1788, when a fur trade ship brought 66 labourers from Canton and Macau (in southern China). Most were hired as carpenters, maintenance mechanics, and sailors. According to the autobiography of the ship's captain, these people settled at Nootka Sound, a fur trade port in southern Vancouver Island (Lee 1967, 34). No further records of that group exist.

Chinese appear again in official records in 1858, the year gold was discovered in the lower Fraser River in British Columbia. Many Chinese joined the rush from the United States.(1) Later, work on the Canadian Pacific Railway between 1881 and 1885 attracted about 17,027 male labourers directly from mainland China. Lee (1966), Lyman (1977), Hardick and Johnson (1975), and Ward (1978) conclude

that economic factors were the main reasons motivating the Chinese to leave their homeland in southern China for the more prosperous West.

However, when the trans-continental railway was completed in November 1885, most Chinese labourers became unemployed. According to Stanislaw (1958, 61) 1,000 returned to China in that year, and about 400 went to Mexico to build another railway (Lee 1967, 135). Those who remained became scapegoats for economic and social problems, because they sold their labour too cheaply (Lee 1967). Many worked on farms, others in forestry, the fishing industry, shoemaking, laundries, tailoring, restaurants, and the domestic service (Canada 1958,2). Because the Chinese were regarded as both racially and culturally "too" different from the dominant white group, assimilation was assumed to be impossible (Woodsworth 1941; Ward 1978).

Government Legislation

Minority status was entrenched by local governments, provincial franchise laws, and federal immigration acts. Chinese were prevented from registering to vote in municipal, provincial, or federal elections (Roy 1981). In order to control and exclude the number of Chinese, the Canadian government imposed a head tax on each Chinese who

sought entry. The tax increased from $50 in 1885, to $100 in 1900, and finally up to $500 in 1903. The law lasted until 1947 (Lee 1967). The objectives of Canada's anti-Chinese legislation were summarized as follows:

> To keep the Chinese in a subordinate position in the economy, to segregate them residentially, and to deny them citizenship through disenfranchisement (Palmer 1972, 57).

This legislation affected the soci-demographic profile of the Chinese in Canada, as it forbade the entry of Chinese families.

> The structure of the Chinese family in Canada was largely determined by the structural conditions of the Canadian society and in particular, the immigration system. Such a system imposed various structural constraints upon the Chinese and prevented them from bringing their families to Canada. The patterns of "separated" families and "married-bachelor" (2) society were products of institutionalized racism and not Chinese or slum culture (Li 1980, 69).

The legislation also influenced the occupational profile of the Chinese (the development of the laundry industry and resturant business); life style (indulging in gambling and prostitution); and social organization (forming Chinese Associations for mutual assistance and to cope with the problems Chinese encountered in their lives in Canada). Siu's (1964, 430) investigation found that laundry work was the first organized occupation started by the Chinese after the completion of the railway.

> The lack of women created great demand for household and personal services. Laundry work, particularly, was a great need in the population of the frontier which was predominantly male.

In fact, in the traditional Chinese family structure, washing, cleaning, cooking and other housework had normally been carried out by the females.

As pointed out by Lore (1974), Stainslaw (1958), and Li (1979), because the Chinese were very efficient in the trades and in commerce, some local governments prohibited the Chinese from working at or owning trades and businesses which could compete directly with the non-Chinese private sector. Thus, the Chinese were forced by market conditions to take menial jobs or to run laundries and restaurants in their own communities. Table 2.1 summarizes the Canadian Immigration Acts which influenced the pattern of Chinese immigration. Basically, they can be divided into six distinct stages.

Table 2.1: Major Canadian Immigration Laws Affecting Chinese Immigrants

Period	Legislation	Effect
1858 - 1885	none	Free Entry
1885 - 1923	Chinese Immig. Act 1885, and Chinese Immig. Act 1903	Restricted by head tax, from $50 in 1885 to $500 in 1903
1923 - 1947	Chinese Immig. Act 1923	Complete exclusion
1947 - 1962	Chinese Immig. Act 1947	Sponsored immigration only
1962 - 1967	Immigration Act 1962	Independent and sponsored immigration
1967 - present	Immigration Act 1967	Universal point system

Source: Lee (1967)

In sum, discriminatory immigration laws and policies determined the occupational profile, family pattern, and organizational structure of the Chinese community in Canada. The dominant group's deliberate use of power to distribute resources resulted in important distinctions between this group and the Chinese. In Newman's (1978) terms, the relations between the Chinese and the host community are basically a form of social conflict. Their relations derive primarily from the "ranking, competing, and coalition of groups in terms of the distribution of valued social resources".

THE FOUNDING OF THE MONTREAL CHINESE COMMUNITY

Most observers, such as Lee (1967, 85), the Gazette (1981), and the Montreal Chinese Quartier (1982), have reported that the first group of Chinese arrived in Montreal in the early 1880's and established their "ghetto" in the southern part of the city. However, further investigation shows that a few Chinese had attended French and English classes run by the Catholic church as early as 1863 near the site of present Chinatown. (3) Thus the close relationship between Montreal's Chinese and the Catholic church developed early in its history. According to some old Chinese Montrealers, the Clark-La Gauchetiere area of Montreal was

the original centre of Chinese development. At the time, it was an abandoned part of the city, about a 10 minutes walk from the CN railway station. (4)

According to Lee (1967, 395), about 3,000 Chinese lost their jobs when the railway was completed in 1885. Some drifted to the CPR's headquarters in Montreal to ask for jobs. Others heard from their countrymen that Montreal was a prosperous industrial city with good job opportunities. More and more moved from the west coast and settled in this new eastern base, starting such typical occupations as laundry shops, restaurants, gambling houses, grocery stores, and other food industries. However, "some just came to explore and then left, searching for a new base," some old Chinese Montrealers reported.

Between the years 1910 and 1945, the total Chinese population in Montreal was about 1,500 to 1,700. They lived in the isolated Chinese ghetto on Clark and La Gauchetiere streets, just north of Old Montreal. Of these, at least 97 percent were males, "married bachelors." Although they were all originally miners, railway builders, or coolies, the small ethnic community became rapidly differentiated horizontally by clan, district associations, (5) and political affiliations with different dynastic powers in

mainland China. Vertically, the community was divided into two distinct social classes: a small bourgeoisie (laundry, grocery, and chop suey shop owners) and a larger group of employees and part-time workers in manufacturing firms.

Before 1920, Chinatown consisted of six grocery stores specializing in Hong Kong imports, four small Chinese resturants, and several gambling and opium dens. Family-run laundries and resturants spread rapidly across the city and to nearby towns. Some Chinese worked as part-time, unskilled labourers and porters for manufacturing firms in the city. Others worked for wealthy Canadian families as cooks and housekeepers. Generally speaking, most Chinese in Montreal sold their physical labour (Crepeau 1950). Many reported long, monotonous working hours and cramped living conditions, particularly those who worked in the laundry business.

Nevertheless, since most shop owners and their employees had mutual blood or village ties in China, employers were usually willing to help their employees set up their own small business in different parts of the city. Capital was normally obtained through the traditional Chinese banking system. (6) According to Li (1982), partnership investment was also one of the most popular

means of establishing an ethnic restaurant. As early as the turn of the twentieth century, there were about 40 chop-suey places opened by former coolies in the city (Crepeau 1950,7). According to Helly (1981,35), between the 1911 and 1922 542 laundary shops opened in Montreal. According to my informants, two to five people worked in each laundry. Through clan and district associations, the bourgeoisie and workers were able to maintain close and co-operative relationships.

The Chinese stayed in Montreal to accumulate capital, hoping eventually tc return to their homeland. Buying land, farms, building larger houses, and finding daughters-in-law for their sons, were always hidden wishes. They had no intention of integrating themselves into the majority French Canadian (or English) societies. Language barriers, culture shock, constant hostility, and harassment had forced them to live in an entirely isolated world. According to some Chinese Montrealers, the only way to survive then was to "help one another in the closed ghetto." As one of them recalled,

> The outside world was unbelievably hostile, they viewed Chinatown as a mystic and horrible place. They thought all chinese were indulging in gambling, opium-using, etc..Very few Canadians came to the ghetto before the end of the Second World War.

The prevailing attitude of the majority toward the Chinese can be seen in the following quote from the Gazette in an article about the rise in the head tax on Chinese from $100 to $500 at the end of nineteenth century:

> An increase in the capitation tax would do no harm. John Chinaman is too much with us.... He displaces Christian labour, and is in no sense a welcome or desirable addition to our population (Gazette 1899, cited in Debates 1899, 4335; in Woodsworth 1941).

Stanislaw's study (1958, 224) on the evolution of Chinese Immigration Acts concluded that the conflicts between Chinese and Canadians were mainly shaped by anti-oriental feelings and by the large-scale influx of oriental labourers, including Japanese and Indians.

Relations With The Catholic Church

The Chinese community's only contact with the external, majority community before the Second World War was through Catholic priests, sisters, and their religious organizations. According to church documents and informants, the Montreal Catholic church started its formal mission among the Chinese as early as 1913, following the return of a missionary who had learned some Chinese in southern China. Masses and sunday schools conducted in

English were arranged for the Chinese on Sunday afternoons in the basement of a school between Ste-Catherine and Ste-Urbain streets, near Chinatown (Caille 1943).

Links with the Catholic church were strengthened when two French Catholic sisters fluent in Chinese returned to Montreal from China in 1916. Within a year of their arrival, the first Chinese school was established in Chinatown. English and French were taught, in addition to Chinese culture, language, and bible studies. The school later became a formal educational institution, and offered formal Chinese education at the primary level until the end of the 1960s.

Formal Social Organization In Chinatown

Before the Second World War, there were less than 20 families in Chinatown. People knew each other by name. The most significant formal social organizations were those of the clan and district, and the all encompassing Chinese Association. The clan and district organizations embodied the traditional spirit stressing relations among blood-linked families, particularly within the same district or village in China. All persons with the same family name are assumed to be descended from the same ancestor.

Prior to the 1920s, family groups in Montreal gathered together on Sundays in small clan rooms in the ghetto. These assemblies played an important social role in maintaining close relationships among people who belonged to the same families. It was in the clan-rooms that "distant relatives" shared problems, exchanged news, played cards, found jobs, and encouraged newly-arrived, distant relatives. After the 1920s, larger clan and district organization buildings emerged to fill the expanding needs of the dominant Chinatown families, prominant among whom were the names Wong, Hum, and Lee.

The Chinese Association adjudicated differences among the different clan, district organizations, and other groups in the community. For example it functioned as an informal court when the clan associations failed to settle their "family business." Externally, it represented the Chinese community as a whole in dealings with the majority community and government.

Since clan and district organizations assumed primary functions in the daily lives of most and were the main focus of Chinese identity, the notion of Chinese nationality remained unclear. Most Chinese valued their families more than their nation. Thus, the Chinese Associations in North

America were not of major importance, though their leaders were recognized as spokesmen by the host community (Nickberg 1981).

Although there were several political organizations in Chinatown after the First World War--including the Nationalist League, the Free Masons, and the Reform Party--they merely represented competing political ideologies in China, and had nothing to do with Chinese relations with local government.

As a matter of fact, the Chinese widely believed that it was not advantageous to be involved in court cases, even when they were wronged or were the victims of discrimination. Thus "avoid entering into a court house in your whole life span," was a famous proverb among the Chinese. Many authors (eg., Lee 1967) have felt that the Chinese would unite only to fight for their survival, not for their rights. This culturally rooted passivity helps explain why the social organizations of Chinese all over North America were so weak compared with those of other ethnic groups.

The value of naturalism emphasizing harmony in all things seems to be behind this passivity. Traditional

Chinese literature espouses "unity between nature and man" as the highest pursuit of human civilization (Walmsley 1959, 3-5). Such values placed the Chinese in North America at a great disadvantage as they encountered western industrial and technological culture, emphasizing competition, individualism, and ethnic discrimination.

However, given that members of the Chinese community came from similar social backgrounds in mainland China, embraced similar ambitions, and experienced similar lifestyles in Canada, their cultural stress on harmony promoted cohesiveness within the group. Despite a hostile external environment, they found satisfaction within the ghetto. To the Chinese of the early twentieth century, then, assimilation was not only unnecessary, it would have been extremely costly and, in fact, unattainable.

The Elites

In its own way, Chinatown was slowly evolving. A new economic class, the bourgeoisie, had emerged. As jobs were always the first priority for immigrants, the bourgeoisie assumed importance as employers. They were also the main providers for the sick, the elderly, and the unemployed and through their clan and district organizations, they became

the official spokesmen of the community.

However, because Confucianism had formed the social, moral, and political ethics of China, traditional elites there were the "grains of intelligence," respected scholars and rulers (Bottomore 1970, 70-71). In China, merchants, had been regarded as living off the labours of others, and occupied the lowest social position. In between were the farmers and artisans (Walmsley 1959, 8-9).

Thus, as merchants, the early elites in Chinatown lacked the proper social image in the community. They encountered difficulty in mobilizing individuals and uniting social groups. The discrepancy between the social image expected of traditional elites and that projected by actual elites had a tremendous impact on Chinatown's social organizations.

The Chinese View Of Health And Illness

It was not until the 1930s that western medical techniques became widespread in mainland China (Chan 1965). Hence, most Chinese who came to North America early in the century subscribed to traditional Chinese concepts of health practice.

In interviewing members of the Chinese community about their health practices, I identified four levels of health seeking behaviour among the early immigrants in Montreal. (1) The male immigrants, dependent on their physical labour to earn money steadfastly followed traditional Chinese health practices embodying the maxims: "staying healthy is a sign of piety to one's parents," and "prevention is always better than a cure." (2) When they did become ill, immigrants typically resorted to herbal remedies brought with them from their homeland. (3) If such self-administered treatment had no effect, a "tai-fu"---a traditional Chinese herbal practitioner----would be called in either to treat the patient at home, or at his place of practice. (4) If the "tai-fu" could not effect a cure, it was generally believed that the patient was on the edge of death. He would then be sent to an occidental hospital. Thus, in the early years, the word "hospital" meant "bad health," "bad luck," and "death" for the Chinese immigrants.

Due to anti-oriental sentiment and language barriers, only a few Chinese who could speak and read English or French, or who had Canadian-born children at home, tried using physician practitioners of western medicine. Most sought out two Chinese "tai fu"--Hum and Tong. These men were associated with one of the earliest grocery stores in

Chinatown, Wing's. Herbal medicines for mild illnesses, such as fever and flu, were imported by Wing's from Hong Kong via Vancouver. The trust placed in traditional healing methods indicates that the community's beliefs, customs, and values strongly influenced their perception and interpretation of illness, and as well as health seeking practices.

THE ORGANIZATION OF PUBLIC HEALTH IN MONTREAL

Status Of The Population Of Montreal

Although there were many diligent Catholic organizations in the province, general health conditions in Montreal in the 1920s were the worst among cities of comparable size in North America. Montreal had the highest rates of infant mortality, tuberculosis, and diphtheria (Copp 1974). This frightful situation was reported by the health statisticians of 1913:

> As in past years, of the 35,904 deaths which we have registered as having occurred in the year 1911, there was the appallingly large total of 17,748 children who died before they had reached the age of five years. This represents 49.7 percent of the total number of deaths of all ages throughout the province (Q.S.P. 1913, vol.47, 3).

According to district inspectors' reports, poor water

supplies, sewage systems, abattoirs, and night-soil deposits were the main causes of contagious disease and illness in the province. As the 1917 district inspector of Montreal recorded,

> Generally, slaughter houses are badly situated, insufficiently attended to, and dirty. Discharging sewage into ditches is yet a very common practice (Q.S.P. 1919, vol.51,pt.3, 29).

Not only was the living environment poor, but the quality of the most common daily beverages, milk and water, was grossly inadequate. For example, a food inspector found that:

> Of 100 examples of restaurant milk collected in Montreal, 78 were below standard in fat or solid-not-fat, and 17 were below standard in both (Q.S.P. 1915, vol.48, 45).

The following description given by the district inspector also revealed the quality of the Montreal water supply:

> In the case of outbreaks of typhoid, when we are in a position to conclusively show that they are directly due to the poor quality of the water supply, the very outbreaks themselves furnish us with a most patent argument in favour of the proper safeguarding of water sources (Q.S.P. 1919, vol.53,65).

According to Abbott (1932), relatively large-scale community measures for the prevention of disease in Quebec only started in 1924, when the General Health League was formed. However, it was merely a volunteer organization of

representative citizens in various districts, not a governmental effort. In fact, in 1927, a survey of public health activities still claimed that "the budget of Montreal's health department provided for per capita expenditure of just thirty-nine cents as compared to an average expenditure in the twelve largest American cities of seventy-eight cents per capita" (Copp 1974, 413). These figures at least partly explain the poor health care services in Montreal.

The Hospitals

Like elsewhere, pre-twentieth century hospitals in Quebec were reserved for the indigent sick, and mentally ill or deficient. Historically, in the English community the larger urban hospitals were sponsored by the wealthy philanthropists who dominated the provincial and some, the national economies. In the French community, religious orders channelled community resources into hospitals. As charitable institutions, early hospitals frequently encountered substantial deficits and looked to their generous supporters in the community as well as different levels of government.

Because the initial investment and financing for early

hospitals in Quebec came essentially from private sources, decisions relating to fixed assets and the establishment of new services were taken within the hospitals by the philanthropists and religious orders (C.I.H.S.W. 1970). However, it would seem because responsibilities in health care were so vague, the decisions made frequently did not meet the needs of the sick.

The Role of Government

Provision for public health and health care constitutes one of the major subsystems of any society. In the nineteenth and early twentieth centuries, the Catholic church in Quebec viewed itself as the protector of French culture, and dominated most social service institutions including health care. It was not until the 1950s that the provincial government began systematically legislating secular social sevice institutions (C.I.H.S.W. 1970).

According to Quebec Sessional Papers and the Commission of Inquiry On Health and Social Welfare, municipal health services had existed in Quebec in an organized manner as early as 1876. However, they had only limited responsibility for "the supervision of aqueducts and sewers, inspection of food, community institutions and commercial buildings" in

clearly established residential districts. In rural communities, services only started after the establishment of the County Health or Sanitory Units in 1925.

Although district officers in each municipality were given the mandate, through provincial legislation, to establish public health organizations and promote popular health education, no municipality could be compelled to enforce the regulations or finance an adequate program. The provincial government itself did not finance capital or operating costs. Its role was merely to pass laws. Thus, public health administration and implementation were essentially voluntary, carried out by community groups and the church rather than by civic government. Health care was left in the hands of the philanthropists and religious orders in Quebec prior to the Second World War.

The Role of The Catholic Church

The close relationship between churches and voluntary social welfare in the West has been richly documented by many researchers (eg., Armitage 1975). Socio-theologically speaking, the hierarchically structured Catholic church serves a universal and transcendental mission directed at shaping the social structure as well as individual life in

the world (Coughlin 1965). Thus, the church sees as proper to its mission a direct involvement in the social order, based on social justice infused with charity.

In Montreal, where the population was overwhelmingly francophone and Catholic, it was not surprising to find the French Catholics intimately involved in the organization of public health and the development of hospitals.

> The early religious [christians] imbued with an ardent zeal to carry out the teaching of the Master, sought out the sick, nursed them in their homes and, at times, brought them to their own homes and institutions where they cared for them; and from these individual efforts there gradually evolved the hospital for the care of the sick... Little wonder then that, with such a background, the French should have been burning with zeal to establish in Canada a hospital... (Beagerty 1928, 145).

Thus, the first hospital in North America, Hotel-Dieu de Quebec, was established in Quebec City in 1639 by the French Catholics. Until the early twentieth century, hundreds of hospitals, asylums, foundling hospitals, and medical-related works were found and maintained by religious orders. In fact, the Catholic church maintained control over most institutions of education and welfare in the province until the late 1960s.

The Role of Medical Professionals and Technology

Public health was not the object of systematic organization in Quebec before the turn of the twentith century. Health and illness were essentially viewed as individual problems. Doctors, without any rigidly formulated ethics of medical practice, provided services in the home. According to MacDermot (1967, 40), there were about 165 doctors practising in Montreal in 1875: "some acted as insurance agents, others conducted apothecary shops. Among the doctors were specialists, electricians, and homeopaths."

As noted by Kett (1967), Abbott (1932), and Tunis (1974), official medical education in Canada did not start until the 1820s. McGill University, opened the first Canadian medical school in Montreal in 1823, patterned on that at the University of Edinburgh. Before this, early enthusiastic individuals had sought their training primarily in Scotland (particularly Edinburgh) and London. After 1830, when the war between France and England ended, many French Canadians went to Paris for training. However, as there was neither a social nor scientific reason for patients to choose well-trained doctors, local, irregular practitioners seem to have received even wider support than

those who were trained abroad.

Following publication of the U.S. Flexner Report (7) in 1910, the establishment of licencing examinations for Canadian physicans in 1912, and with the increased power and recognition given to physicians' associations or colleges, legislation was increasingly used to distinguish formally "trained and qualified" health practitioners from others. On the other hand, the nuns, equipped with faith and love, had devoted more care to the ill than had more formally trained practitioners. The early contribution of nuns in Quebec hospitals was quoted by Canadian Medical Association (1967):

> When one considers the state of medical and surgical practice in the 17th and 18th centuries, and the early part of the 19th, one is forced to the conclusion that the nuns, with their nursing, did a great deal more to cure the patient than the surgeons, physicians, and apothecaries, with their copious, repeated bleedings, their sweatings, their drastic purges and emetics, and counterirritants.

Table 2.2 shows the ratio between doctors, nurses (both religious and lay), and patients in Quebec hospitals between the years 1916 and 1919.

Table 2.2: Ratio Between Medical Professionals and Patients In Quebec Hospitals Before The Birth of The HCS

Year	No of Hosp	No of Physic	No of Relig	Nurses Lay	No of Pat Admitted	Death Rate of Pat Admit
1916	49	262	884	680	42,289	7.58%
1917	48	217	864	858	47,258	7.23%
1918	47	374	888	1056	49,752	8.47%
1919	48	321	884	1027	47,926	7.22%

Source: Q.S.P. 1916-1919

The discovery of the bacteriological causes of postoperative infections and the gradual perfection of ether anesthesia during the last quarter of the nineteenth century are regarded as crucial factors directly affecting the development of modern medicine and hospitals. Toward the end of the nineteenth century and beginning of the twentieth, the systematic body of modern, abstract, scientific knowledge of medicine and skill was being formally and informally recognized by the public.

As new medical discoveries and scientific knowledge

gradually illuminated the complexities of the human body, public funds poured into laboratory research. As a consequence, physicians more and more focused their interests on acute care and narrowed the scope of their expertise to organ systems and sub-systems. Specialization proliferated. Public trust and confidence reached its zenith with the discovery of insulin in 1921 by Banting and Best, and financial support for medical research across Canada increased (Agnew 1974).

Thus the public began to view hospitals in a more positive light. Professional hospital administrators rose to manage the growing numbers of both the health labour force and clientele. The chief responsibility, power, and authority of health care had undergone a major shift toward licenced medical men. They started shifting their services away from home and into technologically based hospitals. These organizational changes verify the tendencies hypothesized by Boulding (1953). He notes that organizational evolution occurs after changes in the habits and needs of people, and in particular, with the evolution of skills and techniques. According to Carr-Saunders and Wilson (1933), the latter is a highly complex process intrinsically related to the processes of professionalization and political change in modern

industrial societies.

CONCLUSION

Before 1918, the Chinese were a small and economically weak minority both in Canada generally and in Montreal in particular. In Montreal they were isolated from the majority and lived in a poor, ghetto area of the city. There, traditional values and practices (including those related to health), as well as organizations based on Chinese clan, kin, and loyality, flourished. These promoted internal cohesion and a certain impermeability vis a vis the broader community.

Ghetto social organization was dominated by a merchant bourgeoisie which did not command the level of respect given to traditional "scholarly" elites in China. Nevertheless, this group, through community organizations, provided a range of services to the immigrant population.

In the broader society of Quebec and especially Montreal, the status of public health was dismal. Public health and health care organization was minimal, and health care technology was still in its infancy. Health care was seen as an individual problem and treatment was provided via

family and church. There was little public policy on health, and the responsibilities of both municipal and provincial governments were vaguely defined. As the twentieth century progressed, however, with developing medical technology and public demand, the health care system began to evolve toward more sophisticated, and acute care oriented services.

It was in, and influenced by, this context that certain events occurred which would lead to the founding and early organization of the Montreal Chinese Hospital in 1918.

CHAPTER 3 DELIVERING AND NURTURING AN ETHNIC HEALTH CARE INSTITUTION (1918-1945)

INTRODUCTION

This chapter uses the framework established in chapter one to describe the links between the social context described in chapter two and the founding and early evolution of the Montreal Chinese Hospital. First I describe the effects of the 1918 influenza epidemic in Montreal. Second, I show how the social context already outlined led to the birth of the MCH. I then describe the early organization and management of the hospital and note how this was also influenced by its social environment. Finally, I discuss the relations between the institution and its ethnic clients on the organization's basic task level.

THE INFLUENZA EPIDEMIC

In Montreal, inadequate public health practices, the anti-oriental sentiment, and poor living and working conditions made the Chinese community particularly vulnerable to the virulent influenza epidemic which swept

Montreal in 1918 (Copp 1974; Maginnis 1977; Quebec Sessional Papers 1920, 1921). (1) All normal functions of the city were paralysed. "Police and firemen delivered food and fuel to those confined to their homes" (Mcginnis 1977, 410).

> In Montreal, the disease was prevalent during the latter part of September and in a very short space of time had spread throughout the city. By the 7th of November there had occurred 17,252 [reported] cases and 3,028 deaths in that city, but a far greater number than this were attacked....Vigilance committees were pressed into service to go from house to house to ascertain if there were any sick or if any assistance was required....The dead were found in beds alongside the wall (Canada 1941, 3).

All hospitals, clinics, and temporary shelters were flooded, and numerous patients were turned away. Said L'infirmiere Canadienne (Sept. 1967, 28), "there is no space for Chinese at all" (1967 sept. p.28). One Chinese Montrealer recalled:

> Chinatown was just like a dead town then. All stores were closed. Everybody stayed home . If we really needed to get something from outside, we got to wear a mask. Wong-Lo-Gup (2) was the only herbal medicine available for us, all laundry shops were full of those "life savers." However, it did work!

Although the Quebec Public Health Act had existed since 1876, it was a defective piece of legislation. As pointed out by Copp (1974), neither the provincial government nor the municipalities really accepted responsibility for public health. Nevertheless, emergency bylaws were passed during the influenza epidemic (Q. S. P. 1921, 13).

THE BIRTH OF THE MONTREAL CHINESE HOSPITAL

The Nuns

In order to help the desperate Chinese, sympathetic nuns belonging to an order called Les Religieuses De l'Immaculee-Conception utilized an abandoned building on 66 Clark Street near Chinatown. They approached the municipal government with a plan to organize a first aid station there for the Chinese community during the epidemic. They received "ten beds and blankets" as assistance. Other necessities and furnishings such as mattresses, sheets, pillows, and dishes were offered by the St. Viateur Clerics--- a brothers' catholic mission in Montreal (Crepeau 1950, 29-31). The station admitted 17 patients on its first day, october 17, 1918. The epidemic ended in june, 1919. Of the 60 Chinese patients treated, 20 had died. In order to show their gratitude to the Catholic church, the Charity Society of China honoured the church with medals the following year (Caille 1943).

The Chinese Philanthropists

As Chinatown grew and evolved, the community had become increasingly aware of the social needs of its sick and

elderly. With the epidemic fresh in their minds, members of the Chinese community considered a hospital in Chinatown an urgent necessity. Health care facilites in their own community would overcome the language and cultural barriers that had plagued them. As one old Catholic sister recalled:

> I heard many old sisters mention that, in the early years [before 1920], there were many Chinese who lay on the beds of chronic hospitals in the city for years, and no one was able to communicate with them. They just lay there day and night, and spent their time by looking at the ceiling only.

Seven shop owners and a court interpreter (three Wongs, two Lees, one Hum, one Chan, and one Wu) met and approached the Chinese Association of Montreal (3) and the elders of several big clans. They solicited contributions from the Chinese community for a permanent hospital in Chinatown, and raised $ 2,000--their target--in a month. Fifty-four people, most of them laundry, chop suey, and grocery shop owners, donated $ 20 apiece. The rest was raised from small individual donations.

The group bought an old, three storey building at 112 La Gauchetiere Street West. The hospital soon occupied the first two floors and basement (the top floor was used by the Montreal Chinese Association). The new hospital was called Yin Yeung Yeun---"the place of long life and health for the aged." It was opened on october 27, 1919.

Early Organization

For the first few months of its existence, the hospital was operated by Chinese volunteers who practiced their herbal arts in return for free meals. The only full-time staff member was a Chinese cook. But the hospital organizers quickly realized the impracticality of this policy. They needed people to communicate in French or English with municipal authorities, to handle referrals and other procedures especially to disposes of the dead.

Mother Delia Tetreault, founder of the Immaculate-Conception order, had been to sending nuns to provide medical services in Chinatown. She agreed to let four nuns reside in the hospital. Further, through church connections, three voluntary, part-time francophone physicians--a general practitioner, surgeon, and throat specialist, were invited to give practice in the Chinese ghetto. The herbal art was thus abandoned by the new organization. On March 20, 1920, the Yin Yeung Yuen became the Montreal Chinese Hospital. A representative of the Chinese government in Ottawa was master of ceremonies at the inauguration.

The hospital's main function was to care for the

elderly and sick married bachelors in the institution. It also acted as an alternative to traditional Chinese herbal medicine in the ghetto. However, most Chinese did not trust western medicine and went to the MCH only when traditional medicine had failed them. Thus, the hospital quickly became a station for emergency cases, referrals, and a refuge for the dying.

In sum, the birth of the MCH can be directly attributed to two social factors: the difficulty the Chinese community had in gaining access to health care services in the external host community, due to cultural and racial barriers and the urgent medical needs of the sick and elderly in Chinatown. The Catholic church, as represented by the Immaculate-Conception Order of Nuns, the legitimate health care agent at that time, was instrumental in guiding the early development of the hospital.

THE EARLY INSTITUTIONAL LEVEL

Chinese Elites

As most Chinese immigrants in Canada before the Second World War were labourers and small restaurant and laundry shop owners (Crepeau 1950; Lee 1967), it was not surprising

to find that the first hospital organizers were neither well-educated nor knowledgeable in medicine. They were elder leaders of the dominant clan and district associations which had emerged in the early years of the twentieth century; small businessmen with little English, traditional Chinese cultural conservatives with strong local social ties. An old community leader recalled:

> They didn't know any formal rules of running a hospital then. They just did something which they thought would be helpful to sick and old people.

This recollection matched one Chinese professor's assessment of the political attitudes of the Chinese immigrants: stressing informal ways of managing things and lacking "the concept of contract" (Cho 1974). The Chinese National Father, Dr. Sun (1979, 342), had stressed that lack of the concept of principle and law was one of the main obstacles hindering the growth of real democracy in China. Lipset et al. (1956) have noted that political democracy has had a stable existence only in regions which have large middle classes and comparatively well-paid and educated working classes.

The Board

The early hospital board was composed of a president,

vice president, secretary, treasurer, and public relations officer. Many informants have reported that the hospital board did not operate democratically. There were no clear rules governing its operation. Thus, there were no regular or annual meetings between the years 1918 and 1945. During this period, only one person occupied the position of president. Similarly, other board members retained their positions for long periods of time.

This situation prompted accusations of authoritarianism by those who felt excluded. This phenomenon obviously reflected the characteristics of an oligarchical control system, the overwhelming power of dominant clan and district associations, and the classical means of Chinese decision making---all of which ignored public opinion and community participation.

Instead, the board secured its power through personal network relationships. It relied on the submissiveness of individual Chinese at the time, the relative homogeneity of the population, and the lack of competing institutions in the ghetto. The legitimacy which the board gained corrsponds well to Weber's (1981) concept of traditional authority; that is, authority based on the belief that he who commands does so in the name of traditions that are worthy of

obedience.

The hostile external environment (reflected in the Chinese Immigration Act) had forced the Chinese to solve their own problems and to provide for their own needs. Through the Montreal Chinese Association, the hospital was able to seek support in the community legitimately, even though most Chinese did not trust or use western medicine. This phenomenon illustrates Simmel's (in Abel 1970, 83) notions concerning group conflicts. He observed that conflict and hostility can serve as a means of establishing unity and cohesion in a group, or to use Breton's (1964) terms, the immigrants' integration into and solidarity with their own ethnic community, supported by its institutional completeness.

Financial Resources

According to the former president of the hospital, between the years 1918 and 1945 the hospital was entirely financed on a voluntary basis. Individual donations and patient charges were the two means of income. In-patients were charged from 50 cents to $ 1 a day before the Second World War. Many paid according to their ability. Occasionally, there was a small income from dispensary

services. Many Chinese in the ghetto were willing to contribute some amount to the hospital each year, particularly during the time of traditional festivals like the Lunar New Year. However, the larger donations came from those who had been in Canada for a long time and were ready to return to their homeland. The figures varied from $ 10 to $ 50.

During serious financial crises, the board members requested donations through the clan associations with which they were familiar. These would then call upon individual families in the ghetto. At times, they even obtained help from other Chinese communities in central and eastern Canada, including those in Toronto, Ottawa, and Nova Scotia. This indicates something of the cohesive social organization among the Chinese during times of hardship and difficulty.

Finally, the board managed the social needs of individual patients. Was the patient really in poor financial straits and in need of special help? What were the consequences if a particular patient was discharged? How was the property left by a deceased patient to be managed? Such problems arose frequently, but because Chinatown was a small community whose members were closely linked through clan and district associations (which stressed helping

relatives of the same family), these social problems were not difficult to solve.

In sum, the entire community was dominated by the residual Chinese feudal ideology of familism, with its lack of legal concept, the behaviour of the board members can also be seen to reflect the local distribution of power: that is, decision making was dominated by community elites. Due to the fact that board members were poorly educated and tended to regard themselves as visitors in a foreign land, there were no long-term plans for the development of the hospital.

The main task of the board was to find financial resources, for the day to day existence of the hospital. As a result, the in-put of resources was slow, and limited. Essentially, the hospital was a community-supported, self-sufficient, charitable institution. It provided limited western medical services to the small, ethnic ghetto. It was perhaps less a healing institution than a symbol of Chinese cultural solidarity, wherein countrymen helped one another during times of difficulty and hardship.

THE EARLY MANAGERIAL LEVEL

The Church and The Nuns

As noted, before the 1920s the hospital hired only Chinese personnel, and patients were treated with traditional herbal medicines. But this policy was soon deemed to be impractical and an agreement was drawn up renewable annually, between the hospital board and the Corporation of the Missionaries of the Immaculate Conception. The main points concerning managment of the hospital were summarized as follows:

> 1) The Corporation of the Missionaries of the Immaculate Conception has the right to manage and appoint all staff in the hospital.
>
> 2) It is the responsibility of the Missionaries of the Immaculate Conception to recruit physicians and not less than four nurses for patient care in the institution.
>
> 3) The hospital board is responsible for all sorts of costs and expenses in the institution, which is payable quarterly in advance to the Corporation of the Missionaries of the Immaculate Conception (HCH 1928)

The hospital board had to pay $ 1,000 to the mother house annually for the services provided by the four nuns. The board was also responsible for expenses such as light, heat, and food for the patients. According to one of the former executive directors of the HCH, "all financial

matters were directly controlled by the board members; the sisters had nothing to do with the money in the hospital; they just stayed there to care for the sick and show the love of God." Thus, the institution's goals were essentially met by the Chinese merchants. This agreement laid the foundations of a French Catholic administration for the hospital. The general supervisor, nurses, nursing aids, and later the laboratory technicians were all to be recruited from the mother house.

Services and Facilities

Services were initially divided into in-patient and out-patient care. Although there was no resident physican, the GP came to the hospital every weekday morning to see both in-patients and out-patients. The surgeon came on Monday and Thursday afternoons, to perform minor surgery and out-patient consultations. The throat specialist was seen by appointment.

A small dispensary within the the hospital provided both out-patient and in-patient medicines. Since the majority of Chinese then living in the ghetto were poor, free prescriptions were given to those unable to pay--except if the medicine was extremely costly.

There were 10 beds for in-patients when the hospital opened in 1920; another five were added in the early 1930s. This expansion signified an increasing demand for hospital beds by the aging sector of Chinatown. Chinese living in central and eastern Canada also sought admission. During the 1940s, both out-patient and in-patient services were in demand. Between 20 and 40 people visited the out-patient clinic each week, and an average of 100 patients were admitted annually during this period.

Although administration and patient care were entirely carried out by the Catholic missionaries, the Chinese cultural heritage was maintained. For instance, the hospital served Chinese food and patients celebrated their traditional festivals. Since the hospital was located in Chinatown, it was convenient for Chinese there to visit friends and relatives, bringing messages from the homeland and their favorite foods. Hospital structures (e.g., visiting hours, admission and discharge procedures, records keeping) were irregular.

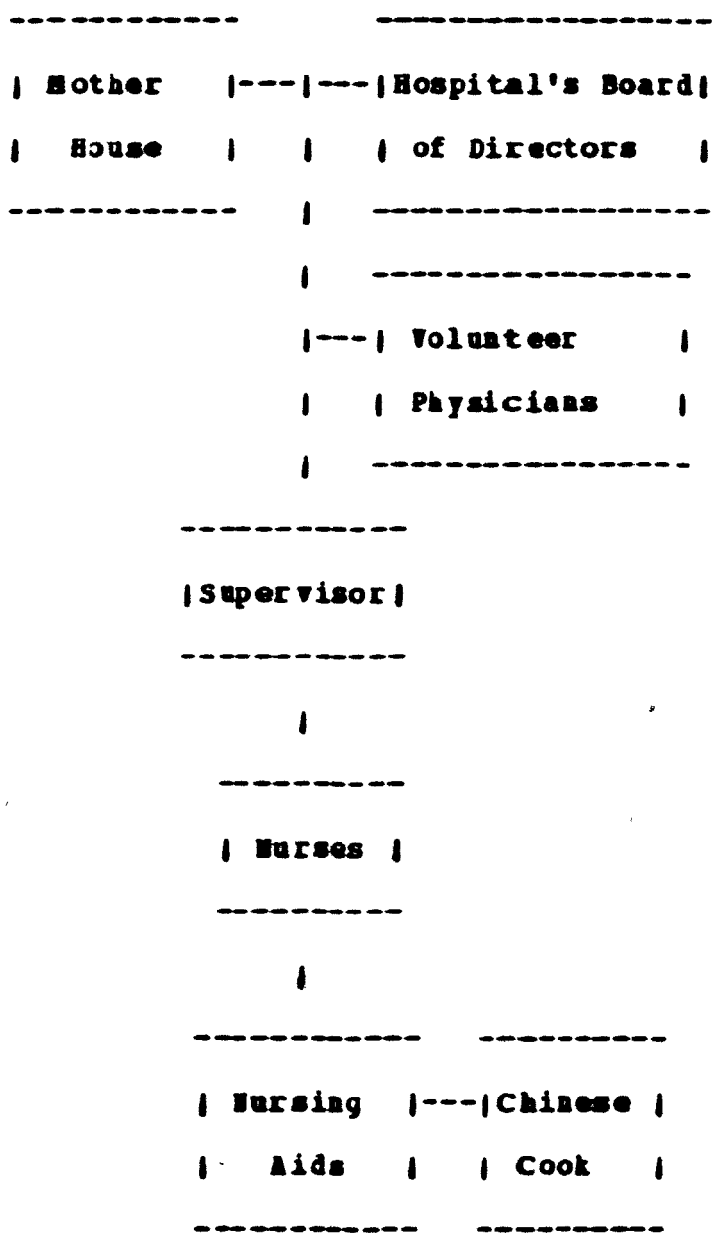
The hospital bought its first modern equipment--a small set of X-ray facilities--in 1930. Ten years later it bought a surgery table. These equipment to some extent widened and modernized the functions of the institution, but in no way

approached those of other hospitals in the external community.

Major decision-making powers within the HCH rested with the supervising nun. Since the board members lacked sufficient background in patient management and language skill, they did not intervene in the hospital's daily administration. The nuns were free to use their discretion in running the hospital. This lack of involvement with hospital routine led the Chinese to perceive the HCH as a Catholic institution entirely ruled by the nuns.

Figure 3.1 shows the organizational structure in the HCH during from 1918 to 1945.

Figure 3.1: Organizational Structure Of The Early Montreal Chinese Hospital



In sum, the Chinese community was obliged to purchase the services of outside professionals for their hospital. They contracted annually with a Catholic organization because these resources could not be found within the Chinese community. The nuns provided the institutionalized mechanisms for recruiting necessary resources from the external community.

THE EARLY BASIC TASK LEVEL

Patients' Response to Western Medicine

Between the years 1920 and 1945, formal medical consultation for the hospital's in-patient and out-patient services were carried out mainly by the two French missionary physicians based at Notre Dame Hospital. They served without pay on a regular basis until 1965. Occasionally, other medical professionals from the same hospital provided free services on request.

As the Chinese then had a bad image of hospitals and western medicine, they regarded the MCH as a place for seriously ill patients and dying old men. Thus, only those at the edge of death, and those who had already lost all hope in traditional Chinese herbal medicine, would

voluntarily be admitted. Further, according to many Chinese Montrealers, Chinese landlords and their lodgers who feared the spirit of the dead, often forcibly carried dying tenants on their bed boards to the hospital. Due to this mistrust, a large number of patients admitted to the MCH were already in the process of dying.

The internal environment of the MCH, was described by a visiting journalist in 1945:

> The hospital has two wards with four beds each, three rooms with two beds, and one private room...During the summer, the hospital beds are not all occupied...but there is often a waiting list of three or four in winter...The hospital contains a pharmacy to fill prescriptions for the patients in the Chinese community. In 1944, 2,868 prescriptions were filled. These were done by Sister St. Yves, Sister St. Georges, and Sister St. John the Baptist M.I.C., who compose the regular staff (Montreal Star 1945).

Language continued to be a barrier between patients and staff, despite the best efforts of the latter. Before a Chinese nun from Hong Kong joined the hospital in the late 1920s, translators were usually brought to the hospital by the patients themselves. Although the situation was not ideal, most Chinese seemed to appreciate the efforts of the nuns.

The Scene On The Wards

Inevitably, some religious activities took place within the hospital. According to Cailie (1943), "sometimes 20-30 Chinese received baptism" in one year. Patients passed their time on the ward reading newspapers and magazines from Hong Kong and exchanging memories of family and homeland. It was not uncommon to hear a dying patient's last wish, "bring my bones back to my family and bury them in the land of China." (4)

The nuns would move dying patients into a small isolated room. The GP or the surgeon would be called in to sign the death certificate as the patient passed away. If the patient had no relatives or friends, the nuns would call the city health department to remove the body.

In sum, despite other activities, throughout this period, the MCH was a chronic care facility, a place where infirm, elderly bachelors, without money or family, lived out their last days. Hospital board members solicited funds to meet the funeral expenses of the old and penniless patients who died at the hospital, particularly if they had the same family name or came from the same village. Money for this purpose was often successfully raised in local gambling and opium dens. Many Chinese in the ghetto were willing to contribute something toward a pauper's burial.

Although the hospital was located in Chinatown and all patients were Chinese, the staff gave the internal environment a distinctively French-Catholic air. Some Chinese felt like outsiders in their own hospital. However, patients probably understood the social meaning of the place--a reflection of the painful lives of Chinese sojourners in a foreign land.

CONCLUSION

An historical, socio-political examination of the Chinese in Montreal before 1945 reveals an economically, politically, and socially underdeveloped group which developed its own hospital in the face of the anti-oriental sentiment and cultural and social barries to care facilities in the host community. The only external assistance came from representatives of the Catholic church, which had a long tradition of providing care for the poor and sick in Quebec. This affiliation with the church provided the conduit through which limited lements of western medical technology, labour, and resources were channelled into this marginal hospital. In a sense, then, the hospital promoted a degree of western medicine among the early Chinese.

Even after the establishment of the hospital, the

majority of Chinese remained skeptical about western medicine and continued to practice traditional herbal medicine. The hospital was regarded not as a place of healing but as last recourse and as an asylum for the dying.

Organizationally, medical science during the late nineteenth and early twentieth centuries was still relatively primitive. Until technology progressed and physicians used their control of it to consolidate a monopoly over health care, they had little control over or interest in hospitals. Thus, the trustee philanthropists who provided financial support dominated the institutions (Perrow 1963). The Montreal Chinese Hospital reflected this pattern, long into the twentieth century till things had changed within hospitals in the broader community. This was because of its ethnic base. Board members, community leaders, and patients, they would seem, had little access to minimal resources for, and little interest in progressing western technology. There were no western-trained physicians who saw the hospital as their primary locus of practice. The nuns who administered there were primarily presuming a work of Christian charity. Thus the hospital remained trustee (and manager) dominated--but largely in the Chinese tradition at the institutional level. Decision making was paternalistic and governed by implicit, cultural rather than

explicit legal rules.

CHAPTER 4 POST-WAR SOCIAL CHANGES IN THE CANADIAN QUEBEC SOCIETY

INTRODUCTION

This chapter discusses a number of social changes related to health care which occurred in Quebec society during and after the Second World War. These changes first promoted universal access to health care regardless of ability to pay which in turn created the need for a more centralized health care system. These factors ultimately threatened the very existence of MCH. Before examining all this however I describe how the Montreal Chinese community changed after the Second World War due both to political development, in China and Canada, and to more cultural factors. These analyses are a prelude to a discussion of the crisis faced by the MCH in the period, 1945-1970.

EVOLUTION IN THE MONTREAL CHINESE COMMUNITY

The Second Homeland

In 1949, the Chinese Communist Party of Chairman Mao

Tze Tung took power in mainland China. The new regime delivered the oppressed peasantry and working classes from the hands of landlords, owners of light industry, and the foreign powers which controlled heavy urban industries (Tawney 1966; Walmsley 1959). The dream of numerous Chinese living overseas to return was shattered. Although their hearts remained in China, they were regarded by the new Chinese government as the "fruits of feudalistic exploitation" (Lu 1956). (1) For the first time they were forced to consider satisfying their needs in the host community and developing permanent relationships with their new homeland.

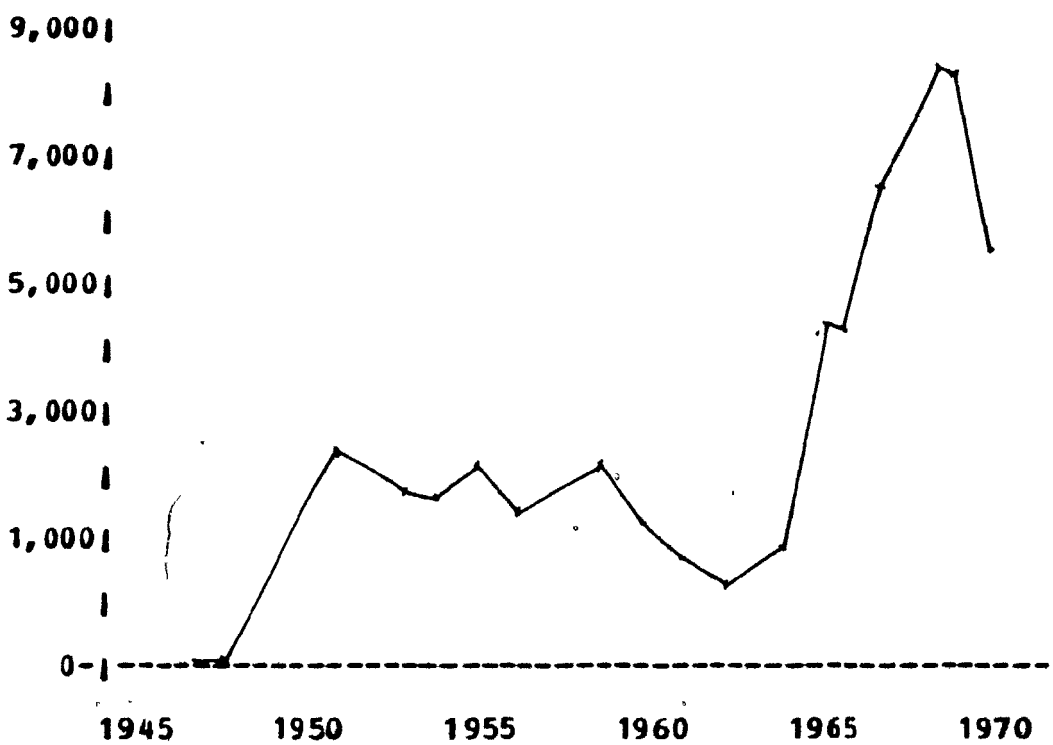
In the meantime, growing numbers of Chinese took advantage of the Chinese Immigration Act of 1947 and migrated to Canada, hoping for family reunions, higher living standards, better education, and/or job opportunities. This trend was further encouraged by the Canadian Immigration Act of 1967 which awarded points for an individual's education, skill, and employment opportunities (Canada 1967).

Many Chinese Montrealers collected money and sent it to Taiwan and Hong Kong to help refugees from mainland China. This indicates that a large number of Chinese here supported

the capitalist system and the regime in Formosa prior to the new wave of Chinese immigrants in the mid-1960s. The new wave of settlers, combined with the maturation of the first-generation, Canadian-born Chinese, rapidly changed the simple dual-class society of shop owners and their workers in Chinatown into one divided by the clan and district associations, spoken Chinese dialects, and political and religious affiliations. Table 4.1 shows the changing pattern of Chinese immigrants entering Canada between 1946 and 1970.

Table 4.1: The Number Of Chinese Immigrants Entering Canada Between 1946 and 1970

1947: 21	1955: 2,535	1963: 1,187
1948: 33	1956: 2,093	1964: 2,624
1949: 734	1957: 1,662	1965: 4,352
1950: 1,746	1958: 2,615	1966: 4,094
1951: 2,708	1959: 2,561	1967: 6,409
1952: 2,320	1960: 1,370	1968: 8,382
1953: 1,936	1961: 861	1969: 8,272
1954: 1,636	1962: 670	1970: 5,377



Source: Canadian Immigration Statistics 1945-1970

Thus, as more and more new immigrants arrived in Montreal after the 1950s, clan and district associations grew larger and more powerful--particularly, the Wong, Lee, Hum, and Chan families. They eventually took over the role of the Montreal Chinese Association, which had traditionally acted as formal representative of the Chinese in negotiations with government. The Montreal Chinese Association was accused by some community leaders of being used as a political tool against the new Communist regime in China. (2) The well-developed clan associations organized recreational activities for the Chinese in the community and provided a "traditional Chinese banking system" to meet urgent financial needs and help business development in Chinatown. (3) Candidates were now elected to the Montreal Chinese Hospital from their own "clan families." As one old Chinese Montrealer recalled:

> Each Sunday [right after the Second World War] I left my laundry shop in Saint John and come to Wong Associatin in Chinatown. We paid our monthly fees [for the banking system] and met our fellow countrymen there. We exchanged our news, played cards and other games [most of them were gambling games] We stayed there till 9 or 10 o'clock at night. Then we returned to our shops again in different towns, either by train, bus, or carriage with the food we bought from the grocery stores.

Although these clan and district associations legitimized gambling and casinos in Chinatown, these forms of entertainment soon disappeared. Many old Chinese Montrealers

attribute this loss to the reunion of families which brought back normal family life and to the city's legislation forbidding public gambling in the 1960s.

Occupational Mobility

Lee's (1966, 403-410) data show that at the beginning of the twentieth century, most Chinese immigrants in Canada were concentrated in labour and service occupations. However, recent studies (e.g., Porter 1965) reveal that Chinese and other Asian immigrants in Canada are moving up the social ladder and are now over-represented in both the professional and service categories. In Montreal, according to Chiang's (1978) survey, 36.8 percent of Chinese worked in "professional and technical" occupation. This compares well with the occupations of respondents' fathers. Table 4.2 summarizes the changes of occupation between the two generations.

Table 4.2 : The Changes Of Occupations Between Two Generations Of Chinese In Canada

Occupation Group	Father's Generation No.	(%)	Son's Generation No.	(%)
Professional and Technical	24	(24.8)	74	(36.8)
Managerial	4	(3.6)	14	(7.0)
Clerical and Sales	32	(29.1)	16	(8.0)
Services	7	(6.4)	76	(37.8)
Manual	30	(27.3)	21	(10.51)
Farm	11	(10.0)	0	(0)
Total	110	(100.00)	201	(100.00)

Source: Chiang (1978, 77-90)

Chiang's study also indicates that more than 55 percent of first-generation generation Chinese Canadians have a primary education or less. However, the average number of years of formal education for their children reached 13 years; 42 percent had received at least a bachelor degree. This dramatic change gradually had a significant effect on the social structure and organization of elite groups and on daily social activities in the Montreal Chinese community. Thus, social institutions other than the clan and district associations gradually emerged and reduced the oligarchic power of these groups within the ghetto. This, as we shall see in some detail would have an important impact on the MCH. (4)

Life and Business In Chinatown

As the number of Chinese immigrants to Montreal increased after the Second World War, more Chinese moved out of Chinatown. This was due in part to the demolition of many buildings in Chinatown and the fact that others were rented for commercial purposes as the number of restaurants and grocery stores rapidly expanded. Those living in areas outside Chinatown found that they came to be accepted by members of other ethnic groups. Moreover, the Chinese appreciated the better living environment for their children

in outside neighborhoods. Thus, after the 1960s, only 500 to 600 old Chinese single men still remained in Chinatown proper. As a journalist noted,

> It is an area of extremes; there are elderly men living in virtual garrets, heatless, lightless, soundless. There are restaurant owners working to the early hours of the morning and then returning to homes in Westmount and Town of Mount Royal...Most visitors don't notice any of this; they come for the food, and leave immediately after (Montreal Star 1969).

According to Crepeau (1950), the traditional Chinese laundry shops gradually faded out with the introduction of washing machines. On the other hand, the number of Chinese restaurants increased significantly. According to old Chinese Montrealers, restaurants and grocery stores in Chinatown increased from 7 or 8 in 1946 to approximately 25 in 1970. Restaurants around the city and in nearby towns exceeded 200. Chinese clothing, handicrafts shops, book stores, bakeries, and the like became popular enterprises in Chinatown.

Before 1970, restaurants in Chinatown were often only open on Sundays, for their industrious countrymen who had this day off. The traditional Chinatown grocery store, on the other hand, was a general meeting place. "There were newspapers to read and things to discuss," a retired laundryman recalled. In fact, shopping there for traditional

food such as salt fish and rice was a favorite pastime for those Chinese living outside Chinatown.

Social And Political Organizations

Two Christian Chinese churches (one Catholic, the other Protestant) emerged after the Second World War to provide language education, Chinese movies, and other religious and cultural activities. Three political organizations emerged: the Nationalist League, which had close ties with Taiwan; the Reform Party; and the Free Masons. The original goal of the last two had been the overthrow of China's former dynastic governments (eg., Ching dynasty). (5) However, when the Communist regime in mainland China gained popularity, their political significance diminished.

As the 1970s started, aspects of the cultural inheritance of the Chinese community had already begun to change. Both the Canadian-born Chinese and the new immigrants from South East Asia (e.g., Hong Kong and Taiwan) had been educated in western thought and value systems. The traditional Chinese emphasis on familism and naturalism seems to have declined significantly, leading to a reevaluation of traditional ethnic patterns. Occupational and residential mobility transformed the Chinese class

system from male-dominated, single-class rule to a more complex system. Inevitably, these new life patterns in the Chinese community brought about different needs and demands in health care. Meanwhile, the appearance of well-educated professionals and of a new-generation of merchants gave rise to a new Chinese elite with both eastern and western values. As we shall see, they facilitated the revival of the Montreal Chinese Hospital in the mid-1960s with a new, more democratically oriented management.

New Ethnic Relations

Relations between Chinese and host communities entered a period of transition between the Second World War and the 1970s coinciding with a change in relations between China and Canada. As Stanislaw (1958,227) noted:

> Canada's immigration policies towards orientals is most likely to be influenced by two interdependent factors: by the attitude of Canada's public opinion to Canadian citizens of oriental origin, and by the nature of political relations of Canada with the particular countries of Asia.

With the emergence of post-war humanitarian thought in western countries, the discriminatory Chinese Immigration Act (which excluded all Chinese from seeking entrance into Canada) was abandoned in 1947. This facilitated a growing pluralism in all spheres.

The Health Perspective

After the Second World War, the Chinese attitude toward western medicine began changing, as more of the population experienced western medicine. There was a Wong and a Tan living in Chinatown; they spoke fluent English and made their living mainly by bringing the non-English speaking Chinese patients to the Montreal General, Notre Dame, or Royal Victoria Hospitals. They remained as interpreters and consultants until the end of the 1960s.

Of the two herbalists--Tan and Tong--who practiced the trusted herbal healing arts in the ghetto, one died in early 1940s, the other returned to China before the outbreak of the Second World War. Hence, apart from self-administered treatments, western medicine became the only alternative available to the Chinese.

According to informants, some herbal practitioners had been among the new immigrants. However, due to French and English language complications in the province, and the limited Chinese population in Montreal, "they arrived, watched, and left for Toronto and Vancouver to make their living." It was not until the early 1970s that the Montreal Chinese Association invited a herbal practitioner trained in

Hong Kong from Toronto to practice in the ghetto. The organization felt the need to continue providing traditional Chinese medicine in the ghetto for those aged who spoke neither French nor English and who adhered to the herbalist tradition.

POST-WAR HEALTH CARE IN THE HOST COMMUNITY

Introduction

The Canadian economy revived steadily after the Great Depression and the Second World War. This favourable climate led to changes in the health care system, and to new social security measures, in sum, to "the foundations of the modern structure of Canadian social welfare institutions" (Armitage 1975).

The federal government implemented national health grant programs between the 1950s and early 60s, viewing them as the "fundamental prerequisites of a nationwide system of health insurance" (Andreopolous 1975,14). These grants subsidized almost all construction, renovation, and expansion of medical facilities (Soderstrom 1978, 27,153). Which were needed because of advances in medical technology during the Second World War (Bloom 1963,17-18; Torrance

1981, 258).

These actions were justified with reference to the principle that society should assure ready access to health-care services to all its citizens on the basis of medical need (Manga 1981). Thus in time uniform hospital services were made available to all Canadians in the early 1960's. No one was to be denied benefits because of age, health, or job status. This ideology in turn helped structure the birth of the Royal Commission on Health Services (the Hall Commission) which further studied the national health care situation. The report of this commission ultimately led to a federal plan for universal insurance of all doctors' services. Both hospitalization and medical insurance would have their impact on health care in Quebec.

Social Change In Quebec

Prior to the Second World War, Quebec was a rural, agricultural, church-bound society regulated by folk customs and characterized by tradition and the importance of ascribed status relations (Rioux 1964, 166). It had a conservative, traditional, provincial government. Lee (1979) has outlined three major social conditions behind the strong

church domination in education, welfare, and health prior to 1960: (1) the general lack of industrialization; (2) a French society which was less sophisticated, more rural, and consequently less educated than English society; and (3) a large urban English population which dominated the commercial world, thus detering the rural population from moving into the city.

According to Verdon (1973,60), Rioux (1959,379), and C.I.E.S.E. (1970 vol. IV,48), urbanization and industrialization had begun to take off in Quebec at the turn of the century. This phenomenon began to change settlement patterns and the economy of the society in many important ways. For example, with the modernization of agricultural methods, surplus labourers were forced to leave their farms and enter local marginal occupations, or emigrate to the cities. Eventually the working class became better paid and more independent of the parishes and churches. Table 4.3 shows the evolution of the urban population by comparison with the total population of Quebec and Ontario from 1901 to 1966.

The changing social and economic conditions laid the foundation for the Quebec Quiet Revolution in the early 1960s, which eventually discredited the traditional power

and the ideology of the conservatives, and led the province to approach the rest of Canada in its social organizations (Rioux 1973). Further, industrialization and urbanization helped create a new group of social elites, the French "technocrats", who would have a profound impact on all of Quebec's institutions including those dealing with health.

Table 4.2: The Evolution Of The Urban Population In Quebec And Ontario (1901-1966)

	QUEBEC		ONTARIO	
Year	Urban Population	%	Urban Population	%
1901	595,616	36.1	879,793	40.3
1911	892,024	44.5	1,252,207	49.5
1921	1,203,698	51.0	1,630,800	55.6
1931	1,683,400	58.6	2,015,665	58.7
1941	1,986,644	59.6	2,269,266	59.9
1951	2,602,276	64.2	2,687,710	58.5
1961	3,937,469	74.9	4,941,228	79.2
1966	4,525,114	78.3	5,593,440	80.3

Source: C.I. H. S. H. (1970)

The Health Sector

Urbanization and industrialization had accelerated the growth and formalization of scientific medicine and increased the demand for curative health care services. This in turn had a significant effect on the division of labour in the health sector. It was in this social context that the health industry blossomed, giving birth to various para-medical professionals, different medical specialists, the purchase of "updated" hospital facilities, the growth of the drug industry, and advertising. Table 4.4 shows the dramatic expansion of the labour force in Quebec hospitals from 1946 to 1967. Table 4.5 shows the rapid increase of gross expenditures for health care services from 1954 to 1968.

Table 4.4 : The Expansion Of Labour Force In Ontario Hospitals From 1946 to 1967

Year	Admin Staff	Medical Staff	Nursing Staff	Other Prof. & Tech Staff	Others	Total
1946	n.a.	752	n.a.	n.a.	n.a.	16,823
1950	n.a.	1,073	n.a.	n.a.	n.a.	22,068
1955	315	1,417	14,035	1,492	16,229	33,488
1960	467	2,538	25,328	3,563	19,834	51,730
1965	1,132	3,190	46,877	4,383	32,711	88,293
1966	1,095	3,488	49,614	4,821	34,017	93,035
1967	1,510	n.a.	56,696	6,626	37,777	102,091

Source: C.I. H. S. H. (1970)

Table 4.5 : The Growth Of Gross General Expenditure For Health In Quebec (1954-1968)

Budget Year	Total Expenditure $100,000;% Of Annual Growth	Expenditure Per Capita Overall Expenditure	Hospital Care
1954-55	63.3 --	14.42	11.43
1955-56	64.7 2.2	14.33	11.22
1956-57	65.9 1.8	14.24	11.21
1957-58	75.6 14.7	15.89	12.68
1958-59	85.7 13.3	17.54	13.86
1959-60	102.7 19.8	20.44	16.45
1960-61	129.8 26.4	25.34	20.84
1961-62	229.9 77.1	43.72	39.45
1962-63	274.6 19.4	51.13	46.60
1963-64	309.1 12.6	56.39	48.96
1964-65	359.1 16.2	64.32	60.40
1965-66	429.4 19.5	75.52	71.86
1966-67	523.3 21.8	90.53	84.90
1967-68	605.8 15.8	103.23	95.08

Source: C.I.H.S.M. (1970)

According to Renaud (1976, 52, 60), municipal health services began to monitor the state of health care services

during the growth of curative medicine. The Quebec government began to experience increased demand for public health services and it sensed, by the end of the 1940s, that "public health was the state's [or province's] responsibility." As the director of public charities reported:

> The proportion of patients of Public Charities in General Hospitals is 15.6%...In the sanatoriums, 88% of the patients are there at the expense of Charities, and the Government is increasingly assuming the full cost, to the advantage of the municipalities (Quebec 1947, 117).

From the 1950s, infectious diseases were under control and no longer the dominant health problem. More sophisticated hospital settings dealt mainly with a range of chronic, acute and other diseases and conditions (Renaud 1976, 40, 51). However, before 1960, Quebec hospitals were still run on a voluntary basis, and most were sponsored, owned and operated by the church, which had assumed the responsibility for providing care and shelter for the poor. Consequently,

> There were long delays for non-urgent treatment, overcrowding in some hospitals despite unused beds in others, poor distribution of specialized services, rising costs, lack of personnel and a serious dearth of capable managers throughout the health care system (Lee 1979, 5-6).

There was a growing dissatisfaction with health care

services, combined with concern for the survival of the French language and culture. A fundamental change in the health care system had become inevitable.

State Involvement

Once the Quebec government had accepted the idea that public health was the state's responsibilty, and had joined the federal hospital insurance program in 1961, it started reevaluating the entire health sector.

> The clergy's monopoly in the different sectors of social development was increasingly criticized. The Hospital Act required that institutions which participated in the hospital insurance plan be administered by a corporation distinct from the mortmain corporation which grouped members of the religious community (C.I.H.S.M. 1972, vol. vi, 55-56).

Consequently, as the new health care policies evolved, they reflected a general process of the transfer of power from church to state, followed by a rapid expansion of the civil service. The reformed civil service evolved into independent bureaucracies (Posgate and McRoberts 1976, 116) emphasizing modern organizational characteristics (e.g., bureaucratic principles, professional qualifications, etc.). As noted in the Annual Provincial Health Report (1962, 173):

> The two main responsibilities of the Division [i.e.

Service of Hospital Insurance] are to insure quality of hospital care and full utilization of hospital beds. The doctors and nurses of the Division visit hospitals at regular intervals to verify the lay-out and general condition of the premises, the comfort of patients, the qualifications and number of personnel, the quality of care, meals, medication and equipment etc. The hospital standards staff also sees whether hospitals admit only the authorized number and types of patients, and whether they abide by hygiene, construction, and Q.H.I.S. regulations.

Table 4.5 shows that the Quebec government dramatically increased its gross general expenditures between the years 1960 and 1965 for health care services.

These moves toward centralization of the health care system constituted a difficult external environment for the Montreal Chinese Hospital in the mid-1960s. Its continued existence came into conflict in certain ways with the ambitious plans of modernizing the entire Quebec health care system. As Berren (1968, 87) noted, "the suprasystem requires specialized functions of the subsystems for its own existence." However, the MCH could not fulfill the purpose assigned to it, its continuity came to be questioned.

CONCLUSION

This chapter has shown that post-war political changes in mainland China, the abandonment of the discriminatory Chinese Immigration Act, the rise of well-educated

professionals and of a new-generation of merchants complicated social institutions in the Montreal Chinese community and directly facilitated a change in the structure and organization of elite groups and the daily social activities in Montreal's Chinatown.

In Quebec society, the revival of the Canadian economy, advancement in medical technology, industrialization, urbanization, poorly organized health care services, and the rise of the French technocrats fostered the ideology that health was the state's responsibility. This resulted in the evolution of a more centralized health care system. It reflected a general process of the transfer of power from voluntary groups to state. All these would have profound consequences for the MCH.

CHAPTER 5 THE IMPACT OF POST-WAR SOCIAL CHANGES: FROM DEPENDENCE ON CHURCH TO DEPENDENCE ON STATE(1945-1970)

INTRODUCTION

Lawrence and Lorsch (1967), Hannan and Freeman (1977), and Perrow (1979) have indicated that an organization's environment holds the key to its survival. This chapter examines the tremendous and almost fatal impact which post-war social and cultural changes had on the Montreal Chinese Hospital. The most important change was growth and enforcement of regulatons governing hospitals associated with the development of a centralized health care system in Quebec. Initially, these factors threatened the hospitals very life. Ultimately, however it transformed the sectarian, church dependent hospital into a non-sectarian one--dependent on the public state. First I describe a crisis which occured to the MCH in the early 1960s resulted from the pressure of regulations. Second I show how this led to the birth of a new MCH. Finally, I show how this new, state dependent MCH in its goals and structures were resulted from the post-war social and cultural changes which we have seen in Chinatown and in Quebec society.

CRISIS AT THE MCH

Discrepancy Between The MCH And Its Environment

With very few changes on all levels, the MCH continued as an ethnic asylum for dying Chinese until 1962. In that year, the city's health unit declared the century-old building unfit as a hospital. Sanitary facilities were insufficient and it was considered a fire trap. The hospital was ordered to evacuate all patients as soon as possible, thus threatening its survival. This threat indicated that a great discrepancy had grown up between this marginal, ethnic institution and the Quebec health care system as it had evolved.

Despite significant improvements in medical technology and quality of care, accessibility to health care services, and the possibility of government intervention, the MCH had remained static between the Second World War and 1961. In that year Quebec claimed benefits offered by the Federal government through its Hospital Insurance Act. Since it would be paying fifty percent of all hospital costs. The province set up the Department of Standard Division to oversee the quality of hospital care and the implementation of regulations, especially in the fields of administration,

medical direction, clinical and technical services, and the professional training of hospital personnel (Quebec 1961, p. 207).

Table 5.1 compares the mortality rates for 10 ethnic groups in Quebec between 1945 and 1951. The Chinese had the highest death rate for all age groups.(1) Old Chinese Montrealers, journalists, and city authorities all recognized that health conditions and services were very poor in Chinatown.

Table 5.1 : General Mortality Rate For 10 Common Ethnic Groups In Quebec (1945-1951)

Ethnicity	Year						
	1945	1946	1947	1948	1949	1950	1951
Chinese	20.4	24.27	20.63	19.12	15.57	15.36	22.58
English	8.8	8.92	8.56	8.75	8.94	9.00	9.50
French	9.3	9.16	8.98	8.72	8.62	8.35	8.38
German	7.4	7.20	7.54	9.33	8.01	7.88	9.23

Indian	15.6	19.11	16.56	14.66	19.40	14.33	15.79
Italian	7.4	7.52	6.90	6.62	7.39	6.54	6.12
Jewish	6.8	7.31	6.81	7.72	7.60	6.90	8.46
Polish	7.4	6.76	7.76	5.86	7.64	9.45	6.18
Russian	12.3	18.90	12.57	15.49	13.91	15.19	10.49
Ukranian	7.2	6.16	7.91	6.01	8.26	8.11	6.35
Average Rate of The Year	9.3	9.23	9.01	8.82	8.78	8.48	8.61

Source: Annual Report of Health Department Quebec Government 1945, 389; 1946, 243; 1947, 222; 1948, 226; 1949, 228; 1950, 242; 1951, 258.

The social context was clear. Just as it had been challenged by municipal health officials, soon the hospital would become enmeshed in the provincial mechanisms for the control of health care.

Why had the gap become so great? A contextual analysis of the history of the Chinese in Montreal, the strength of the hospital, and social conditions during the late 1950s, suggests two hypotheses: either hospital directors had noticed the changes in the external environment but did not wish to bridge the gap; or because of their ethnic background they simply did not command the resources to adjust to the changes. Some proponents of the open systems perspective predict that organizations tend to move toward differentiation and elaboration to correct their malfunctioning and readapt to the environment. As Von Bertalanffy (1968, 19) stated, the organism is essentially reactive. Outside stimuli are answered by responses which strive to maintain the system. However, the evidence in this study indicates that the hospital simply did not have the resources to adapt to environmental changes. The poor relationship between the hospital and the Chinese community, the apathy of individual Chinese toward the services it provided, a board of directors whose authority was based upon traditional norms but who lacked knowledge about modern management and medicine--all explain the gap and crisis which resulted from it. Table 5.2 shows a decrease in the turn-over rate of in-patients from 80 in 1957 to 48 in 1961 (the year before the old hospital was condemned).

Table 3.2: The Rate Of Turn-Over And Mortality Of The In-patients Before The Hospital Was Condemned

Year	No. of Beds	No of Pat Admitted	Average Occup.	Mortality Rate
1957	25	80	93.3%	18.7%
1958	25	86	89.2%	16.2%
1959	25	74	92.6%	10.8%
1960	25	64	95.7%	6.2%
1961	25	48	93.8%	14.5%

Source: Quebec (1957, 164-165; 1958, 194-195; 1959, 158-159; 1960, 162-163; 1961, 158-159)

THE BIRTH OF THE NEW MONTREAL CHINESE HOSPITAL

A New Corporation

The Chinese community was concerned about the threat to the survival of their hospital. Though not all Chinese supported it, there was a widespread, sentimental attachment to the hospital. The board invited a Catholic lawyer who had business dealings in Chinatown to help deal with the problem. Under his legal supervision, the old hospital board was dismissed immediately for reorganization. A

preparatory general meeting for all individuals concerned with the continuity of the hospital was called. Letters were sent to recruit physicians, professionals, and businessmen from both Chinese and host communities. The original board members, the Chinese Catholic church, and the nuns who were involved in the hospital acted as mediators among the hospital, Chinese, and host communities.

A new corporation was established with a board composed of Chinese and non-Chinese physicians, hospital administrators, other professionals, and businessmen. Its objective was to build and operate a non-profit, non-sectarian hospital which would serve the general public, and in particular the Chinese community. They planned to raise a budget of one million dollars much of which would need to come from the Chinese community.

Meanwhile, the city's health unit was aware that 22 elderly patients were still being treated at the Chinese hospital. It did not wish however to assume the responsibility of shifting these patients to other hospitals. The reasons for this it seems, were the bed shortages in the face of increasing numbers of elderly, chronic patients. Hence the city health unit "recommended" the hospital corporation's plan to the provincial health

department.

The Quebec government, however, questioned the need for a Chinese hospital in Montreal. They based their argument on the census of 1961, which showed that there were only 3,998 Chinese in the province of Quebec. However, French-Catholic priests, nuns, and physicians who were working among the Chinese argued that the Chinese population had already reached 7,000 in 1963 and that there was an urgent need for health care services because of the higher proportion of aged Chinese in the ethnic compared to the host community. In addition, new Chinese speaking immigrants from South Asian countries would also benefit, since they would encounter language barriers in regular hospitals. According to the former president of the MCH, who was involved in the negotiating process, the Catholic authorities' influence on decision making in the provincial government was a key factor in the outcome.

Needs In The Host Community

At the time, health experts were increasingly citing the need for more chronic-care beds in the near future. As Rynard said in the House of Commons:

> I have been told over and over again that it is almost as cheap to tear down a building and erect a brand new one as it is to repair an old one and equip it with all the modern technology that has been involved since it was first built. This would give work to unemployed people in all fields and professions...More beds must be provided for the chronically ill because, as the human span of life lengthens, we have more people ill. These beds must be provided through grants to municipalities, or else we must pay hospitalization to approved privately run homes (Debates 1963, 4749).

In Quebec, a committee known as "Planning Committee-Convalescent and Chronic Hospitals" was organized by the provincial government in early 1963 to review hospitalization needs for chronic and convalescent patients in the Montreal area, as well as to determine the number of beds required in the future. The committee's preliminary report, made the following recommendations:

1) that 500 additional beds for convalescent and chronic patients be set up in Montreal;

2) that the Department of Health and the Department of Family and Welfare strive to co-ordinate their policy on an efficient basis through more frequent contacts, and that they create a permant placement centre for convalescent, chronic, and domiciliary care cases;

3) that all private convalescent and chronic hospitals be required, under the regulations, to consider 40% of their beds as ward beds (Quebec 1964, 237).

The Result

All of these factors, together, helped save the MCH. When the hospital corporation pledged to serve the needs of

all ethnic groups in Montreal, the federal and provincial governments released $ 350,000 and $ 117,256 respectively for the building fund in 1964. The remainder had to be raised by the hospital organizers.

Immediately, a fund-raising committee was formed. The corporation invited prominent figures from Ottawa and Quebec to be patrons: they include the Lieutenant Governor; the Premier of Quebec ; the Chinese Ambassador to Canada; the Minister of National Health and Welfare; and the Mayor of Montreal. Stimulated by the corporation, social organizations in Chinatown responded by actively participating in the fund-raising campaign.

The hospital received about $ 800,000 from both the general and the Chinese communities all over Canada. Many Chinese consider these fund-raising campaigns to have been the greatest Chinese sucess in Canadian history. Law (1967) attributed their success solely to the participation of community leaders. He ignores, however the stimulus of specific social and medical conditions existing in both the general and Chinese communities.

Decision to Move

During the crisis period, the corporation recognized that the majority of Chinese had spread over the island of Montreal. Very few Chinese still lived in Chinatown. Thus, the new hospital came to be built at the centre of the city, near Jean-Talon Metro station. Some Chinese bitterly resisted the move. However there was no alternative due to the lack of land in Chinatown. The corporation also found that the provincial government was opposed to building the new hospital in the ghetto or in the nearby downtown area, because these areas were already overcrowded with other hospitals.

A New "Ethnic" Hospital

The hospital moved into a new, three-storey building on 1750 St. Denis street on September 22, 1965. It had all the characteristics of a modern hospital. The organization of work and division of labour resembled the formal structure of local general hospitals. Although the hospital was supposedly open to all, it was basically designed to meet the special health needs of the Chinese community.

Internally and externally, the institution looked Chinese. The building was covered with red bricks which symbolized "luck" in the traditional Chinese culture.

Chinese paintings and decorations decorated the walls. It was divided into three sections for in-patient services: there were 17 beds for long term and more or less permanent custodial care, and 31 beds for chronic and convalescent patients who had some hope of discharge. Most of the rooms accommodated four patients, except for a few semi-private and private rooms. In addition, the hospital opened eight beds on the third floor for an obstetrics department, which had 12 bassinettes for new-born babies.

What caused the change from general apathy and minimum support for the hospital to enthusiasm and maximum support during the crisis? Warner and Srole's (1945, 284) interpretation of ethnic survival suggests a partial answer:

> Some of the unsuccessfully mobile turn hostile to the host culture, develop increased feelings of loyalty to their ethnic traditions, become active in maintaining their ethnic subsystems, and prevent others from becoming assimilate.

My interviews with the Chinese in Montreal suggest that it was only in the late 1960s that perceived discrimination by the host community began to diminish--and then only slightly. Therefore, it is not difficult to understand why many Chinese would support their own hospital. With a legitimate organizational goal meeting the criterion of the public interest, the dying hospital received tremendous

support from both the general Catholic and Chinese communities.

THE EFFECT OF POST-WAR CHANGES ON THE HOSPITAL

THE INSTITUTIONAL LEVEL

The Entry Of New Chinese Elites

After the Second World War, more and more Chinese had become frustrated with the hospital. Some labelled it as an "unclean place," some called it a "ghost-house." The institution began losing input from its own ethnic base. It could only deal with patients on a day to day basis and did not undertake long-term planning. These conditions set the stage for the entry of the new-generation of Chinese elites when the crisis occurred in early 1960s.

The new Chinese elites were characterized by higher education, professional status, and higher social aspirations. Most had assimilated western values and ways of management, and considered themselves full-fledged Canadians. Thus, they challenged and eventually destroyed the legitimacy and power of the old Chinese elites by

acquiring power in the new corporation. The corporation sucessfully instituted new values and goals for the hospital and consistantly recruited new members with similar values and goals from both Chinese and host communities.

In the beginning, the Catholic lawyer advised the new corportion. The hospital board consisted of 15 members: Chinese physicans, prominent merchants, a priest, engineers, and chartered accountants. Three were hospital administrators from other local hospitals. Their vision was to free the hospital from crisis situations and expand other services to the growing Chinese community.

Naturally, the new hospital board functioning according to the accepted norms of western industrialized democracies. It was characterized by a high degree of diffusion of power, systematic work procedures, and bureacratic organization in the hospital. Meetings and elections were held regularly. Table 5.2 shows the changes in both number of individuals, of Chinese and non-Chinese ethnic origin, and their occupations, on the board of directors between 1963 and 1970.

Table 5.2: The Changes In Sizes, Ethnic Origin And Occupations Of Members In The Board Of Directors (1962-1970)

Occupation/Year		1963	1965	1968	1970
Hospital Administrator and Physician		0	6	5	6
	(%)	(0)	(40)	(35.71)	(42.86)
Other Professionals eg. lawyer, minister		1	5	4	5
	(%)	(14.29)	(33.33)	(28.57)	(35.71)
Businessmen		6	4	5	4
	(%)	(85.71)	(26.67)	(35.71)	(28.58)
TOTAL:		7	15	14	14
	(%)	(100)	(100)	(100)	(100)
Ethnicity					
Chinese		7	10	8	9
	(%)	(100)	(66.67)	(57.14)	(64.29)
Non-Chinese		0	5	6	5
	(%)	(0)	(33.33)	(42.86)	(35.71)
TOTAL:		7	15	14	14

This table suggests the new relationship among host community, Chinese community, and the hospital. The new board members' higher occupational status also reveals that the hospital's potential for development was getting increasingly stronger, particularly after the mid 1960s. The board members were drawn from economic, religious, and administrative elites. They appreciated the bureaucratic procedures initiated by the Catholic lawyer, who had solid experience in the legal procedures of health care organizations, and they relied upon the support of the hospital administrators. This kind of input from the external environment for a Chinese institution in the Canadian context was unusual in the history of the Chinese in North America.

Financial Situation

After the Second War World, inflation and rising medical costs have left the hospital in a desperate situation. The hospital charged $1.50 a day from in-patients, and it received $ 2 per patient per day from the city welfare department. Tag days, lotteries, and the like were used to raise money each year. However, this was not enough. As one hospital official told a newspaper reporter:

> Until 1957, the Sisters still obtained food for the hospital by begging in the city's farmers' markets (Gazette 1964).

The MCH administration eventually sought help from the provincial government. In 1957, the hospital was accepted as a charity institution under category B-3. It was classed as a hospital for chronic and incurable patients. The Quebec Public Charity association paid $ 4.50 per patient per day to the hospital. Nevertheless, the financial situation remained desperate until the corporation built the new hospital. In 1963, for the first time in its history, the hospital's annual financial report stated that "the hospital is in sound financial situation with a good cash position and no debts other than current accounts which are all paid monthly." (Auditor's Report 1963).

The situation further improved when the hospital received official accreditation, granted provisionally by the Canadian Council on Hospital Accreditation in 1968. It was then qualified to accept the benefits offered through the Quebec Hospital Insurance Plan, which had been implemented in 1961 and which fully subsidized the hospital's operating expenditures.

Concurrently, the hospital gained greater support from both general and Chinese communities, and particularly from

middle-and the upper-class Montrealers. Early hospital organizers had invited many prominent Montrealers to join the hospital's corporation. Through these social networks and personal relationships, the hospital had received many donations and gifts in its early years. The new hospital board regained the support from the Chinese community which it had lost during the crisis period. Therefore, the hospital had strong Chinese input from the mid-1960s to the implementation of medicare in 1972. Appendix B shows the financial differences between the old and the new hospital.

A New Battle

A dream of turning this marginal health care institution into a real, Chinese mini-general hospital blossomed the minds of many people concerned about the growth in size of the Montreal Chinese community and its health needs. However, even in the new hospital, organizers had to struggle to define its objectives, its relationship with Chinese and local communities, and its role and function in the fore-seen centralization of the province's health care system. A president's address to the Corporation in 1968 revealed the conflict the hospital was experiencing at this time:

> As you know...the second floor, for chronic and convalescent patients, is running at full capacity at all times....The third floor, housing the active section, has been the subject of very serious and soul-searching discussion at our Directors and Medical Board meetings. How can we utilize the bed-space and personnel most effectively? Should we expand, and in what direction?...When the new hospital was being built in 1964, it was envisioned that a larger hospital could serve the needs of the Chinese community better. Private and corporate funds were donated with this understanding in view. Whatever evolves in the future cannot fail to take this into consideration" (MCH Annual Report 1968, 5).

The ethnic hospital was becoming the victim of centralization, which affected all spheres of its operation. As one informant administrator claimed:

> As the medicare came in, we knew there's no more chance. For we all feel that it's not hard to raise money from the community to build a hospital, however, it's hard to get the money from the government to run an ethnic general hospital.

In its first five years, the new hospital board focused on development of the hospital's acute functions. However, as the government took control of the entire health care system, the role of the board and corporation would become less important since government took on the task of defining goals and procedures, while the roles of administrators and physicians become also important but only insofar as they were implementing the managerial procedures and technical norms desired by the government. But these could only occur in the post-1970 period. Let us look at the managerial

level in the present 1945-1970.

THE MANAGERIAL LEVEL

Coalition Between Nuns And Non Organizers

The new corporation proposed a five-year contract (rather than the former one-year contract) to the Mother House. The new contract required the Mother House to supply three trained administrators to run the hospital: an executive director, a nursing director, and a person to control finance and personnel. The hospital board would assign medical directors for various medical and paramedical departments.

The new administration's most important goal was to tighten procedures, recruit more trained personnel and gain official hospital accreditation from the Canadian Hospital Association. It won that accreditation in 1968. It was the label "hospital" which had guided and attracted the chief organizers and executives. It was the label which gave meaning, pride, and glory to those people who had fought for the hospital. As one of its chief executives said,

> The team [the board members and the chief executives] was proud of the hospital's performance for

> obtaining the accreditation in less than three years time, for most of the hospitals in the province have to spend from seven to ten years...All of us really worked very hard for that at that time. In fact, the hospital means everything to the president of the hospital. His life is the hospital! The hospital is his life!

The goals of the new hospital during this period emerged from a continual process of negotiation and co-operation among the coalitions of the more powerful participants. The new Chinese elites were rewarded by a renewal of their territorial, institutional, and cultural identity; the nuns were rewarded in having an object, toward which to exercise their belief in the value of Christian charity.

The Administrative Structure Of The New Hospital And Ethnic Employment

According to the hospital's annual statistics, the following numbers of paramedical and service personnel were employed from 1966 to 1969:

Administration	7	Medical Technicians	4
Nursing staff	24	Service Aids	10
Physiotherapist	1	Orderlies	6
Dietitian	1	Part-timers	15

About 25 to 30 percent of the employees were Chinese; some

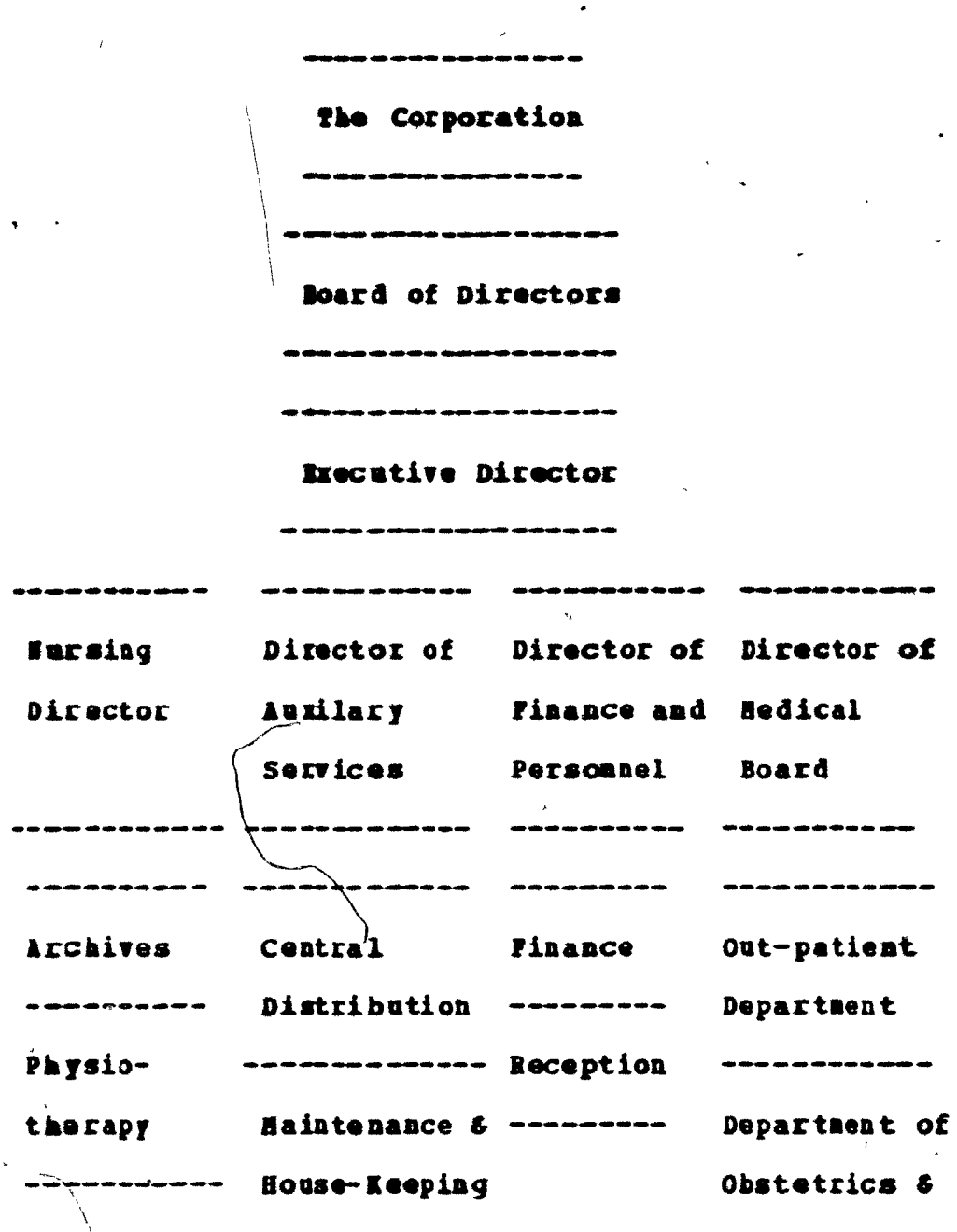
were nuns from the mother house, particularly among the nursing staff and technicians; the rest were French-Catholics. Most part-timers were orderlies and nursing aids.

However, as Montreal was not the first priority for most Chinese immigrants equipped with English as their second language, qualified Chinese registered nurses were not easily found prior to 1970. An ex-staff member said:

> Only those who spoke neither good English nor French were willing to work at the MCH...If they were good in English, they could have found jobs elsewhere. In fact, the work load in the hospital was much heavier than in other places in the early years. The pay was also less than other hospitals. During that period, I had to fill out 40 patients' records each night, in 1968. The hospital administration requested us to keep good patient records for future references.

Most Chinese workers in the hospital were aids, receptionists, kitchen workers, and clerks; few were registered nurses. Thus, the Chinese represented the middle and lower stratum in the hospital. Figure 5.1 shows the administrative structure of the new hospital from 1965 to 1970. Table 5.3 shows the percentages of the Chinese workers in the hospital for the years 1962, 1966, and 1970.

Figure 5.1: Organizational Structure Of The New Hospital (1965-1970)



Occupational -Therapy	Kitchen Service
Laboratory	Laundry
In-patient care	
Pharmacy	
Gynaecology	
Department of Surgery	
Department of Radiology	

Source: Annual Report 1968-1970

Table 5.3: Ethnic Employment In The MCH

Ethnicity/Year	1962	1966	1970
Chinese	2	45	56
(%)	(20.00)	(28.85)	(27.72)
Non-Chinese	8	111	146
(%)	(80.00)	(71.15)	(72.28)
Total	10	156	202
	(100)	(100)	(100)

Source: 1962: interviews. 1966 and 1970: TP4 forms of all hospital workers including the physicians.

A large number of nuns occupied important positions in various departments at the hospital. Other staff members got their jobs through relatives, business and social relations with the hospital organizers or chief executive personnels. The hospital administrators could easily exercise their control over the different departments. "Managing the hospital is just like managing a home; most people knew each other very well," an ex-administrator said. The hospital board tried hard to find qualified Chinese paramedical personnels both locally and overseas. The effect was minimum.

In sum, during the first five years of the new hospital's existance, the French Catholic administration team maintained a very close relationship with the new corporation and the board of directors. Former executive directors used words like "terrific" to describe their working relationship during this period. The nuns not only brought managerial skills to the hospital, they also found a variety of devoted labourers through their church and family networks. The executive director, the financial controller, and the nursing director were sent from the mother house

with the vision of erecting a small, multi-function modern hospital.

Different departments---supervised by various pro-ethnic, non-profit-oriented physician-friends---were able to maintain a high spirit of co-operation and harmony in the hospital. The French Catholic administration realized the needs and hopes of the Chinese community and, in particular, the ambition of the hospital's corporation and directors. As the executive director wrote of his hope for the future development of the hospital:

> The hospital is not mainly for chronic patients; it ranges among the "general" hospitals" (NCH Annual Report 1969, 7).

THE BASIC TASK LEVEL

Post-War Scene

Although the physical appearance of the hospital in Chinatown did not change much after the Second World War, the advances in the medical technology, increased recognition of social, psychological, and economic needs, and the government efforts to improve efficiency with respect to costs, quantity, and quality of health care did have an effect on the hospital's work organization and task

performance. It tried to react to changing social conditions; however, materially, the hospital remained weak.

The supervisor of the hospital described the problems of providing appropriate services with limited resources as:

> even more difficult than my similar experience in Africa. No one would believe there exists such a hospital in a city like Montreal! It is ironic---an old man was sent to the hospital from the Montreal General to practice walking with the help of a pushcart-type affair to lean on. There is not enough room between the beds to push it!

In 1957, in order to qualify as a charitable institution and be covered by the Quebec Charity Act, the hospital expanded from 15 beds to 25 beds by converting the Chinese Association's meeting hall into a ward. It also increased personnel from four to six; began keeping proper health records; and began notifying the city health unit of its mortality rate, percentage of welfare recipients, and the like. This type of information had not previously been well organized.

Before the hospital moved to St. Denis Street, all patients seemed to be of the same social class: retired laundry workers, cooks, and unskilled labourers who had lived in Chinatown for many years. They all received the same kind of treatment, service, and food. Occasionally, a

few patients had their own private physicians. In-patients spent their days lying in bed. Due to limited space, only a few patients could move around. Others simply read or watched TV. Most of the in-patients suffered from such chronic diseases as diabetes, hypertension, and stroke. Some were blind.

Many inpatients kept sums of money on their person because they distrusted occidental banks. Hence, the hospital purchased a safe in which to keep this money. Patients used their money to buy cigarettes, magazines, special foods, and the like. Occasionally, after a patients' death, "distant relatives" would come to claim the remaining money.

In The New Hospital

Once the new hospital was built, the number of Chinese patients attending the services increased steadily. Table 5.4 shows the rate of in-patient occupancy and the recorded number of out-patient visits from 1966 to 1970.

Year	Rate of occupancy (In-patients)	No of Visits (Out-patients)
1966	83.3%	1,168
1967	87.2%	775
1968	92.9%	1,002
1969	94.5%	1,268
1970	96.7%	1,594

Source : Hospital census and Annual Report, 1966 - 1970.

Among the out-patients, about one third were non-Chinese while the rest were Chinese. Among the Chinese, a large number were elderly people from Chinatown and new immigrant families from lower and lower-middle districts of the city. Among the in-patient services, although the occupancy rate of the maternity ward rarely reached 50 percents of its capacity, the department gave the hospital's existence special meaning. The chief hospital organizers and executives frequently regarded that department as the "active section" of the hospital. As one of the former executive directors noted:

> The active section gave the hospital very special meaning before it closed in 1969. Each time, as a new baby was born, it was a big event for the whole hospital. Many elderly patients went upstairs to

watch the new babies. It gave the hospital life and hope.

An examination of the hospital's admission records reveal that, before medicare, the new hospital had the highest patient turnover rates and the highest admission rates in all its years of existence. During this period, there were equal numbers of Chinese and non-Chinese patients. This indicates the hospital's evolution toward a new role and status as an acute and not totally "ethnic" institution. The hospital was aiming for acceptance and support from the non-Chinese milieu.

Technology And Ethnic Doctors

In keeping with its intention to become a modern hospital, the institution was able to update its equipment and facilities by buying a new X-ray machine, two small surgery tables, and more laboratory equipment. Either Chinese or non-Chinese specialists were in charge of X-ray, laboratory, surgery, obstetrics, internal medicine, and out-patient departments before medicare. In addition, board members considered offering mental health services to the Chinese community. This demonstrates the hospital's aspiration to evolve into a mini-general hospital.

Half of the 12 attending physicians from 1965 to 1970

were non-Chinese; of these some were Vietnamese and the rest were either English or French speaking. At that time, Chinese physicians were difficult to find. To deal with this dilemma, the board invited physicians from Hong Kong and Taiwan. This, however, was problematic. Some of the in-coming physicians used the hospital as a stepping stone in their careers, while others were either too poorly trained or had difficulties in obtaining provincial licenses as the Quebec College of Physicians and Surgeons raised their requirements. As one staff member noted:

> Frankly speaking, years ago, before the visits of the investigators, we had to disguise quite a lot of things. For some people [physicians] they got different training from places not so well developed...We have to do something on the patients' records which they had filled out. It was really a big trouble!

Thus, the non-Chinese physicians contributed a highly developed expertise and served as a link between the hospital and the general community. Their presence strengthened and enhanced the new hospital's image. Nevertheless, as the institution had no major facilities, many patients in need of sophisticated treatments were referred to the more prestigious hospitals. The residual image of an old-age home discouraged many Chinese from seeking possible help in the institution. They preferred other hospitals even when there was a language problem.

CONCLUSION

This chapter has shown the great selection pressure which the environment exerted on the marginal, ethnic institution through health regulations in the early 1960s. The direct government intervention had transformed the church dependent hospital into a non-sectarian, state dependent one. It has shown the important roles played by the new-generation Chinese elites and the Catholic church. The coalition of these two forces provided the main resource and support for the continuity of the institution. The bargaining power of the nuns resided in their ability to secure capital and perform technical tasks. For the new-generation Chinese elites, they legitimated their claims by espousing the ideology of "ethnic services" to the Chinese community. However, tightening government control could only allow the presence of a chronic institution with nominal Chinese cultural features. Moreover, the organizers were gradually aware that the future development of the hospital did not rest in their hands, nor in the Catholic church's. A tension was developing as the environment changed.

CHAPTER 6 CENTRALIZATION AND AN ETHNIC HEALTH CARE INSTITUTION IN A PLURALISTIC SOCIETY (1970-1982)

INTRODUCTION

This chapter analyses the impact of further government intervention on the MCH in the early 1970s. First I examine the Chinese in the Canadian context of the 1970s by looking at the effect of assimilation upon the group's medical beliefs, social organization, and its relations with the host community. Second, I describe the reform and new legislation enacted and their effects on Quebec's health care system. Finally, I use the above framework to scrutinize the structural and behavioral changes in the MCH.

1982-PROFILE OF THE MONTREAL CHINESE COMMUNITY

Ethnic Identification

In 1982, Montreal had an estimated total Chinese population of about 35,000.(1) Which can be divided into four main groups based on differences in dialect and culture, and socio-economic status:

1) Toisanese and Cantonese-speaking Chinese, who came from Kwangtung province after the repeal of the Chinese Immigration Act 1947. Most came from the towns of Toisan, Kai Ping, En Ping, and Hsin Wai (Lee 1967, 431; Chang 1978, 76). Few sojourners who came to Canada before the exclusive Chinese Immigration Act 1923 are still alive. However, this remains the dominant, socio-economic group in most Chinatowns in North America.

2) English-speaking descendants, of the first group, both those born in China and in Canada.

3) Chinese English and Mandarin-speaking students and professionals who came from various areas of Southeast Asia, including Taiwan, Hong Kong, Singapore, Malaysia, and China, in the early 1960s.

4) Recent immigrants who came from Chinese settlements in Asian countries under the Immigration Act of 1967. This group includes the Chinese refugees ("boat people") from Vietnam, Laos, and Cambodia. Liu (1975, 32) points out that this group is quite different from the previous immigrants: it "contains many highly educated and professional people....Many among them are well-to-do and they came to Canada for a peaceful existence.".

Thus, the Chinese community in Montreal is

differentiated horizontally by country of birth and/or last permanent residence, clan and district affiliation, and religious and political preference; and vertically by education, occupation, income, and area of residence. Many Chinese live in middle-class areas such as Ville St-Laurent, Town of Mount Royal, Outremont, LaSalle, the South Shore. They are entrepreneurs, professionals, and semi-professionals. Less-successful families live in Park Extension, Van Horne, Cote De Neige, and Rosemont. Among the latter are men who work as cooks, waitors, and grocery store workers, and women who are often sewing machine operators in garment factories.

Ethnicity And Medicine

Most of the Chinese in groups 1 and 4 speak neither English nor French. They are either old immigrant couples, old sojourners, or new immigrants. Social agencies in Chinatown estimated their numbers in 1982 at between 300-400. These are people who need special attention in attaining adequate medical services because they have serious language problems, or they lack sufficient knowledge about the local health care system, or they are accustomed to traditonal Chinese medicine. In 1982, five Chinese physicians, four specialists, and

one GP run five clinics in the old ghetto which are open four weekday afternoons and one morning. Each clinic sees 70 to 100 patients a week. Most of their clients were elderly Chinese and new immigrants with serious language problems.

Five shops sell Chinese herbal medicine in the ghetto; three of these offer consultations for traditional Chinese medication. One runs a clinic with acupuntcure service. Each of these traditional practitioners see five to fifteen patients a week; most of them are elderly woman and, occasionally, their children. Most patients suffer from chronic illnessness such as rheumatism, skin disease, gynaecological ailments, and stomach illnesses.

There seem to be three possible reasons why traditional Chinese healing arts are no longer popular in Quebec: (1) Western medicine has gained popularity rapidly among the North America Chinese immigrants. (2) Most patients must pay to consult herbalists because their services are not insured under the medicare system. Hence, clients only seek out traditional practitioners when western medicine cannot cure them. (3) The costs and quality of herbal medicine are

unpredictable. The price for filling a prescription varies from $ 10 to $ 50. More important, some Chinese do not have confidence in the limited stocks of herbal medicines which traditionalists keep on hand. (2)

Business In Chinatown

Chinatown is bounded by Dorchester Street on the north, Vitre Street on the south, Elizabeth Street on the east, and Fleury Street on the west. The area is full of Chinese restaurants and grocery stores. According to a government city planner, Montreal regards Chinatown as an important tourist attraction, though it is a "type of no-man's land, full of parking lots" (Gazette 1981). Several large building complexes are now being constructed in the area. According to community leaders, these will block the growth of the "ethnic base." Some even view Chinatown as confronting "oppression and crisis" (Montreal Chinese Quartier 1983).

In 1982, Chinatown had about 25 to 30 restaurants and grocery stores, five book stores, several arts and crafts shops, a few bakers, several food manufacturing firms, two florists, two travel agencies, two hair

saloons, one weekly newspaper, several professional and business associations, and a few sports and cultural clubs. Some informants said that the number of business shops had not changed greatly from the 1970s to the early 1980s, though the types of businesses had diversified. Many shop owners complained about high rents due to the high demand for shop space. More than 200 Chinese restaurants have emerged throughout the city of Montreal; ranking from family run "take outs" to luxury restaurants.

Social Organization

The political organizations and clan and district associations formed at the beginning of the 20th century have become almost totally inactive in community affairs. They only open on weekends for a few aged Chinese who wanted to read, chat, or play cards. Most continue to hold annual banquet meetings, at which attendance sometimes exceeds 1,000 people. Apart from maintaining blood-ties, and reinforcing ideological beliefs (especially against the Communist regime in mainland China), the main purpose of these organizations and associations is to encourage the traditional Chinese banking system. In Montreal, there were at least 1,000

Chinese who still use the Chinese banking system in 1982. (3)

In 1982, 750 Chinese adults attended eight Chinese churches in Montreal: seven were Protestant; one was Catholic. The churches were the only social organizations which had fairly stable memberships. All other social organizations in Chinatown were facing instability in their personnel, funding, and membership. This suggests that either the Chinese were immature in running their volunteer associations, or that the associations were still in the latter phases of a transition period from traditional Chinese personalistic organization to western democratic bureaucracy. This phenomenon was apparent in the social organization of the MCM.

Assimilation

Since the Second World War, many Chinese have conformed to Canadian values and customs in various degrees in order to meet the needs which the ethnic community can no longer satisfy. Many individuals succeeded in amassing material wealth. Many have climbed the ladder of success through educational and vocational training. The entire community has begun to broaden its formal and informal relationships

with the host community and with other ethnic communities in Montreal. In Gordon's (1964) terms, cultural and structural assimilation have begun. However, whether the majority of Chinese maintain certain spheres of traditional culture (such as values, beliefs, language, and diet), whether the group shares a sense of people-hood with the members of the host community, is still a topic for further study.

New Settlers

Table 6.1 shows that since the 1960s, there have been more professionals and technicians among the new immigrants from Hong Kong and Taiwan. It is the members of this group, and Chinese students at local colleges and universities, who have been responsible for the major social changes in Chinatown. Cultural and social service organizations, voluntary social service associations, and Chinese radio and TV all blossomed in the early 1970s. Although these young people were neither prestigious community leaders nor industrialists, their actions changed the daily social life of the majority of Chinese in Montreal. Through the new immigrants and students groups, Chinese culture gained recognition in the mainstream society. This phenomenon coincided with the fact that the original leaders were either on the verge of retirement or were second-generation, Canadian-born Chinese.

Table 6.1: Occupational Changes Among Chinese Immigrants Entering Canada In 1960, 1970, and 1980

Occup/Year	1960 (a) (%)	1970 (b) (%)	1980 (c) (%)
Administrative and Managerial	2 (0.85)	104 (4.79)	191 (4.38)
Professional and Technical	136 (57.63)	1073 (49.40)	1984 (45.54)
Commercial and Clerical	25 (10.59)	530 (24.40)	796 (17.65)
Service	56 (23.73)	344 (15.84)	872 (20.01)
Manual and Others	17 (7.20)	121 (5.57)	541 (12.42)
Total	236	2172	4375

Source: a. Origin and Intended Occupation of Immigrants. Immigration Statistics. 1960, PP.10-13.

b. Country of Former Residence and Intended Occupation of Immigrants. Immigration Statistics. 1970. PP. 16-19. c. Intended Occupation and Country Last Permanent Residence. Immigation Statistics. 1980. PP. 40-47.

Note: a and b under China, c under China, Hong Kong, and Taiwan.

Table 6.1 clearly reflects Canadian immigration policies which have shifted from racial criteria to economic criteria. Canada is now more concerned about the potentials (both skills and capital) of new immigrants (Hawkin 1972; Wood 1978).

A New Conflict

The emergence of a new generation of Chinese elites during and after the 1960's intensified the conflict between the Chinese and the Quebec society because the Chinese openly identified with their ethnic origin and culture, and expressed different socio-economic and political objectives. Such tension could be observed in the struggle over the future of Chinatown, in the voting patterns of the Chinese during the 1980 Quebec Referendum

on independence, and the migration of Chinese immigrant families from Quebec since 1980. Many young Chinese teenagers are planning to further their English education in other provinces, and young professionals and semi-professioals who speak little or no French are looking beyond Quebec. (4) This has heightened the sense of confrontation between the Chinese and the host French society. As Breton (1972) pointed out, the different position and objectives among different groups have created and affected all institutional spheres in the Quebec society.

CHANGES IN THE HOST COMMUNITY

The Reform

In December 1966, the Parliament of Canada adopted Medicare Act S.C. 1966-1967, chapter 64, and the Assistance Plan S.C. 1966-1967, chapter 45. These laws assured Canadians access to medical care. When a province joined the federal plan, about two thirds of the care cost would be paid by the federal government insurance (C.I.H.S.H.1970 vol. IV, 17-18). These laws revealed that the Canadian government favoured a progressive and comprehensive health care progras for the

people as a whole.

Quebec faced its own unique and historical problems, including high unemployment, lower income, higher morbidity rates, lower life expectancy, and a low proportion of the population with private health insurance (Taylor 1979). Moreover, the new bureaucracy in the health sector realized the province lacked mechanisms to discuss Quebec's health care problems. In order to solve these unique social and historical problems, Quebec felt that it needed a special health care system designed to fit its own needs. The Castonguay-Nepveu Commission was established in 1966 to evaluate the Quebec's special needs. In particular, the commission was to investigate:

1) the ownership, management, and medical organization of hospital and social welfare institutions;

2) existing hospital insurance;

3) the establishment of health insurance;

4) medical practice and the evolution of medical and para-medical activity;

5) social assistance measures and their development;

6) the structure and role of diverse agencies and associatins engaged in health and social welfare;

7) hygienic and preventive measures;

8) medical and para-medical personal and equipment;

9) education and research (Lee 1979, 6).

Four years later, the commission reported that there was an absence of systematic organization in the province's care distribution: regional and social disparities, such gaps in the evolution of health services which produced, for example, long delays in non-urgent examinations and treatments. In hospitals, professional and technical personnel were found poorly distributed. The commission also saw the need for preventive, as well as curative, medicine. They emphasized "reducing the rate of hospitalization for treatment of acute illnesses and increasing the rate of utilization of general health services, particularly services for health education, prevention, and screening purposes" (R.C.I.H.S.H. 1970 vol IV, 252). It called for a decentralization of services and decision-making processes and the need for standardization and equalization of health care professionals. This would be achieved, it argued, by involving the consumer and the community in the administration and planning of the health care system.

The New Legislation

The Castonguay-Nepveu Commission's report provided the

basis for Bill 65, an act to organize health and social services. It was passed in the National Assembly in December 1971 (At the same time, Castonguay became the Minister of Health, Family, and Social Welfare). The new "open health system" focused on the regionalization of health services, and attempted to combine both social and ambulatory services at the community level.

The Ministre Des Affaires Sociales (MAS), a central coordinating body, was created to distribute funds and coordinate the work of various health and social service organizations. The ministry standardized costs, fee scales, wages and the like, adapting a more "socialist" perspective than had previously been the core. Local community services centres (CLSC), departments of community health (DSC), and regional social service and health councils (CRSSS) were created to decentralize management and decision-making in the system. The councils were composed of officials and citizens living within each region, and were mandated to promote coordination if the various services being scrutinized to local needs. They initially had no budgetory authority however and were largely advisory.

The Quebec Board of Professions (OPQ) was also established through Bill 250 to redefine and standardize

roles, services, and duties of "independent professional practice." The bill gave the government stricter control over the health professionals, including doctors, dentists, pharmacists, optometrists, and dental hygienists. The board also ensured that professional corporations adopted a code of ethics and arbitration procedures for its clients, as well as effective disciplinary procedures for each profession. Hence, the board tried to ensure that professionals "act in the public interest."

Furthermore, all previously approved budgets for hospital construction were cancelled to permit the reorganization of chronic and primary care and review the allocation of resources. The bill's follow-ups gave new hospital boards (which were mandated to include: health professionals, workers, and consumers) the job of allocating yearly global budget. Bill 65 and its associated legislation came into effect in November 1970. Services were jointly financed by federal and provincial governments. However, benefit schedules for physicians in the province were negotiated between the Ministry of Social Affairs and the organized medical professionals (i.e., the Specialists and General Practitioners' Federations). The provincial hospital authorities were essentially responsible for approving hospital budgets and for licensing and inspecting

health care services. The window was also opened for public participation and accountability.

The Effect

The reorganization of the health care system has changed structures in the hospitals and shifted power from religious and philanthropic groups to government based "technocrats". Government has become the important source of decision making. Professionals and philanthropists became associated with the administrative arm of the provincial health care system. The line between the interests of the wealthy, the professionals, and health care consumers has faded, though not disappeared. Renaud (1981) argued that the reforms had only involved a certain reallocation of resources among various elite groups.

However, the interests of small institutions such as the MCH were represented neither by the state nor the regional elites on the councils of various districts. Because of its dependence on state funds, MCH became part of the "network" and the Chinese community lost its control. The opening of a democratic window for public participation and accountability through regionalization seemed ironic to the ethnic minority group. (5)

ORGANIZATIONAL ANALYSIS OF THE PUBLIC HEALTH CARE INSTITUTION

THE INSTITUTIONAL LEVEL

Restricted Ethnic Autonomy

Before the implementation of Bill 65 in 1972, the policy making processes of the MCH still depended upon the Chinese's own ability to cope with the external environment. The members of the hospital board, who were mainly merchants and other Chinese and professional elites, sought every possible means to improve and develop the new value and meaning of the ethnic health care entity. The board members were aware that the Castonguay report would become the offical government perspective on health reform.

On the other hand as early as in December 1967, the year that the Parliament of Canada adopted the Medicare Act, the MCH was also aware that its future development did not solely rest in the hands of the hospital itself or the Chinese community. The health reform was intended to slow rising health costs. In order to comply with government policy, the hospital closed its obstetrics department in 1969.(6) Hospital organizers then argued that since the

government made no special concessions in providing other acute services to the Chinese, it would be legitimate for the hospital to maintain such services for the non-English or French speaking Chinese. For instance, a "diagnostic centre on an out-patient or short-term admission basis" was widely discussed among the board of directors before the implementation of Bill 65. However, as this plan "envisaged considerable changes in the hospital's physical plant," the hospital eventually abandoned the plan.

In 1971, as the Quebec government began reorganizing the provincial health care system, the hospital began to expand its out-patient department, which it would have preferred to close down for its low attendance. In 1972, the hospital expanded its out-patient department from one GP to seven specialists and one GP. Eventually, the hospital realized that the out-patient department was the only acute-oriented service which it could develop further, especially since the provincial Ministry of Social Affairs officially classified the hospital as a "hospital centre for prolonged care of long-term patients" in early 1973. This implied that any other ethnic purpose could no longer be built into the hospital organization. The hospital had totally lost the control of its "end products" which was regarded as the most important factor in recruiting

potential inputs from the external environment for all human service organizations (Hasenfeld and English 1979). The charm of autonomy and self-maintenance had gone with the wind.

Impact On The Corporation

Before the implementation of Bill 65 in 1972, the hospital board was composed of prestigious local businessmen, community leaders, and senior medical, law, and business professionals from both the Chinese and the major community. Their goal was to erect a modern multi-function Chinese hospital in Montreal. The corporation behind the board had the absolute power to purse this goal. Table 6.2 shows changes in the social backgrounds of the corporation members after the implementation of Bill 65.

Table 6.2: The Changes of Social Backgrounds Among the Corporation Members For The Years 1968, 1975, 1982

Year	67-68	74-75	80-81
Owners of Large Companies eg. national firms	10 (21.74%)	8 (18.60%)	6 (13.33%)
Local Merchants eg. resturant owners	11 (23.91%)	10 (23.26%)	7 (15.56%)
Senior Executives eg. administrator	15 (32.61%)	13 (30.23%)	12 (26.67%)
Professionals eg. MD, lawyer	10 (21.74%)	12 (27.91%)	20 (44.44%)
Total	46	43	45

More than half of the corporation members (24 of 46) resigned after the implementation of Bill 65. Most were wealthy local businessman and senior professionals in the city who were regarded as "important and influential members" by the hospital's core organizers. They were replaced by less prominent young professionals. The early organizers were clearly disappointed. As one told me during the interview:

> Before medicare, we had very powerful people in the Corporation, some were lawyers, some were famous businessmen in Montreal...We got support from big banks like the Royal Bank of Canada and the Bank of Montreal, the requirements of joining the Corporation were very high at that time. However, during recent years, we are lacking such strong people to head the Corporation, we have lowered the requirement of membership....Now, we just look for people who have average status, with good reputations in the community, and are willing to devote some time to the hospital.

This phenomenon indicates that the centralization process had deeply disturbed the ethnic community. The hospital adapted to changes in the health care system at the cost of some major and adverse changes in valuation. It survived by sacrificing the values which it deemed essential: it did not have any power to influence the system and was bound to share and agree with what the mainstream society defined.

A New Board

The hospital dissolved its board of directors in 1972 to meet the demands of Bill 65. A new board was formed under the government's instructions. However, this change weakened voluntary support from both the Chinese and the major communities, and it frustrated some early organizers and devoted supporters of the MCH. Appointees of the Lieutenant-Governor, elected recipients, and nonclinical and clinical hospital staff formed the new representatives of the new hospital board of 12 members. As the corporation could only hold four seats on the board, their power waned. This caused dissatifaction among the corporation members, with the new legislation and the future development of the hospital. As one of them commented:

> If I were in the committee [the Board of Directors] I would have pushed the government to finish building the old Folk's Home much earlier. I don't exactly know how the present committee was dealing with the government!

New Strategies

In an attempt to protect the minimum "ethnic boundary," the Foundation of the hospital was formed in 1972 "to hold funds and to receive new donations and other gifts," and "to safeguard the corporation's assets and provide funds for

medical research and such needed development projects for which Government grants were not available." This phenomenon clearly revealed that the ethnic institution was both looking for compensation and for ways to grow.

Selectively "matching" the environment's constraints with its own organization was a special characteristic of the ethnic health care institution. As chronic care had become one of the biggest health care issues since the early 1960s, the hospital proposed to the Minister of Social Welfare construction of an old age home beside the hospital. According to the Hospital's Annual Report (1975) and to some informants, "the proposal was well received in Quebec city." The plan was upset by the fall of the Liberal government in Quebec in 1976. One of the hospital's chief members recalled:

> The negotiating process was complicated. We had been to Quebec City many times to meet the government representatives there. Finally, we got the promise from the former Liberal government. However, the PQ government comes up...They froze the whole plan for more than a year, just said that "we want to make our own investigation." Again, we travelled up and down to Quebec City. We found it's quite tough to deal with the PQ government, particularly if your French is not good enough. We did encounter many difficulties. Finally, we went to see the former Liberal representatives and asked them to fulfill their promise. They did keep their promise and helped us to push the present Quebec government. It worked! However, it had involved the help of many our

friends.

In 1979, the Parti Quebecois government granted the MCH $ 2 million to build a 44-bed building beside the hospital which would serve as a reception centre for old-age people. The building was completed in 1982, at a total cost of $ 2.6 million. The cost overrun was due to the delay in approval.

THE MANAGERIAL LEVEL

Serving The New Boss

Bill 65 gave the hospital a new employer: the Quebec government. Before Bill 65, the corporation had the power to choose any capable candidate to manage the hospital. However, Bills 65 and took effective control of the the hospital from its board of directors and professional employees. One of the hospital's chief executives said:

> As this is a public hospital, entirely funded by the government, except its corporation is Chinese, there is nothing here which is really Chinese now. The government is the real boss. They control everything. We have to following their regulations and instructions carefully.

Clearly, as the main source of money for the organization changed, so did its objectives. As a result, financial issues have become the most touchy areas in managing the

hospital since medicare. The personnel at the managerial level have become particularly anxious about their annual budget. One of them said:

> In order to survive, we have to plan our budgets very carefully and maintain good standards of service. For the government evaluates our performance by looking at the money they spent on this hospital and the services we provide to the community. Thus, we tried our best to limit our expenses. We spent less money, but provide more and better services than the other similar hospitals.

This change illustrates Perrow's (1963) paradigm of administrative dominance phase due to the increasingly non-routinizable functions and sophisticated interdependent, specialized health services in modern hospitals. More efficient and economical operation are the major concerns. Because physicians are less interested in competing for power in a chronic hospital, the power possessed by the French managerial staff has become extremely overt at the MCH.

The MCH's administrators complained to me about "piles of paper work to fill out from the government," adding that "good hospitals do not really need government intervention." Said one administrator:

> We have to play with politics: for instance, I seldom call the district office to discuss serious business.

> In order to make these 'big' people understand what is Chinese, I will usually call them before lunch time and meet them in Chinatown. While they are eating the Chinese dishes, I explain to them the unique needs of the Chinese population. The other thing is my trip to Quebec City to meet those provincial representatives. Usually, I take the eight o'clock plane in the morning and arrive there approximately at nine. When I get there, they are usually still having coffee or reading newspapers. I know I am wasting my time to get there that early, however I know that I could gain time by loosing time.

Ethnic Employment

As all the chief executives in the hospital were not Chinese, a French Catholic team formed naturally. They controlled all access to the hospital's key positions and were highly concerned with maintaining their status quo. Ethnicity and religion had gradually become the most important dividing line between the Chinese and the French Catholic staff. This created two separate social worlds; one Chinese, one French Catholic. There was no real social interaction between the two groups apart from the gestures of courtesy: "Hi" and "Good-bye."

Although the hospital has admitted more Chinese patients since 1970, a careful investigation of all full-time and part-time staff revealed that, after Bill 65, the percentage of Chinese employees in the hospital dropped significantly. The following tables show the gradual

increase of Chinese patients and decrease in the percentages of permanent or temporary Chinese staff workers.

Table 6.3: Total Number Of Chinese Patients Admitted In 1970, 1972, 1974, 1976, 1978, and 1980

Year	1970	1972	1974 (a)	1976 (a)	1978 (a)	1980 (a)
Chinese	44	40	29	25	20	13
(%)	(48.35)	(57.97)	(74.36)	(83.33)	(74.07)	(86.67)
Non-Chinese	47	29	10	5	7	2
(%)	(51.65)	(42.03)	(25.64)	(16.67)	(25.93)	(13.33)
Total	91	69	39	30	27	15

Source: Admission Records 1970, 1972, 1974, 1976, 1978, and 1980. a: low turn over rate after the implementation of Bill 65. The hospital was officially classified as a "hospital centre for prolonged care of long term patients" by the Ministry of Social Affairs in 1973.

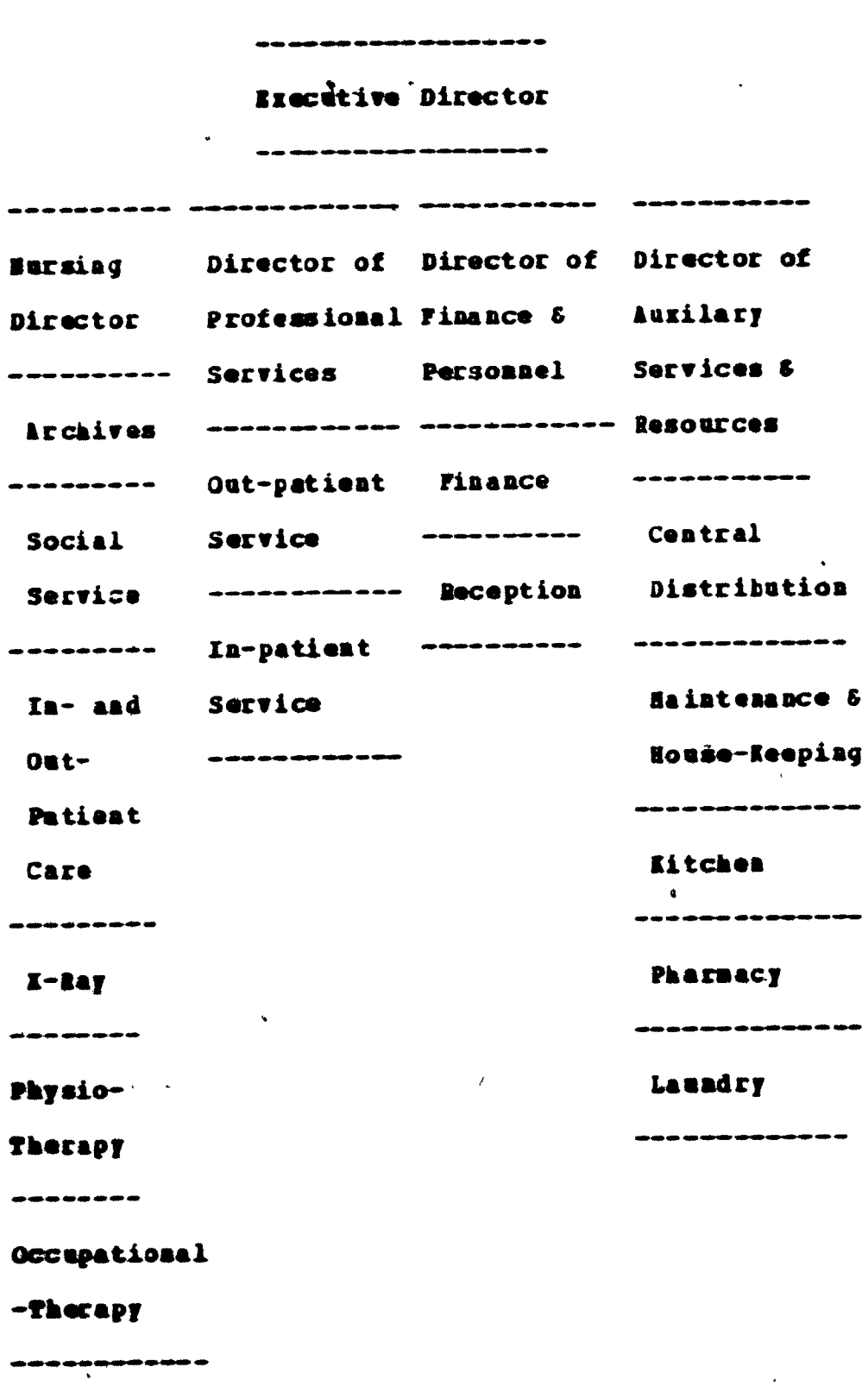
Table 6.4: Total Number of Chinese Working Full or Parting At The Hospital

Year	1966	1970	1974	1978
Chinese	45	56	32	31
(%)	(28.85)	(27.72)	(16.84)	(16.67)
Non-Chinese	111	146	158	155
(%)	(71.15)	(72.28)	(83.16)	(83.33)
Total	156	202	190	186

Source: TP4 forms of all hospital staffs for the years 1966, 1970, 1974, and 1978.

Figure 6.1: Organizational Structure Of HCH After Bill 65 (1972)

Board of Directors


Executive Director
Nursing Director
Director of Professional Services
Director of Finance & Personnel
Director of Auxilary Services & Resources
Archives
Social Service
In- and Out-Patient Care
X-Ray
Physio-Therapy
Occupational -Therapy
Out-patient Service
In-patient Service
Finance
Reception
Central Distribution
Maintenance & House-Keeping
Kitchen
Pharmacy
Laundry

In 1981, most Chinese employees at the hospital were stratified at the middle and the lowest stratum. In fact, the latter is overwhelmingly represented. They include receptionists, aids, orderlies, and clerks. (7) A Chinese staff member complained:

> When they need people in the relatively higher positions, French is more important than any other qualification. Even when they hire ward staffs, they just care if the person can communicate with them in French, not with the patients who speak Chinese.

Since the end of 1970s, the hospital began hiring some French-speaking Vietnamese, who spoke little or no Chinese. I found that many of the Chinese employees were bitter about the jobs they held or had held. They felt there was no future for them at SCH, and used expression such as "no other choice," "as a stepping stone," "moon-lighting," or "self-sacrifice" to explain why they worked there. Others said: "I am still studying at school and waiting for chances." "I found this job, it doesn't bother my regular family life, so I stay." "I was invited to work here by XX and XX." "Many people just used this place as their stepping stone, if I could find a better job, I won't hesitate to leave!"

As for hiring criteria, [choice between English- and French-speaking] the following excuse was common among the

French staff:

> As the patients understand neither English nor French, it really doesn't matter to hire more French speaking staff to work here.

The administrators seem to forget, however, that most Chinese who work at the hospital have little or no knowledge of French. Some of the Chinese workers feel they are deprived of information about what is going on in the hospital. In order to ease the tension, devoted corporation members stressed the traditional Chinese merit of respecting and looking after the aged.

The Social Structure Of Internal Control

Although officially all job vacancies in the hospital are open to the public, I found that social networks among families, churches, organizations, and friends played crucial roles in the hiring process. A reliable informat commented:

> Besides knowing French, if one knows nobody here, there is no room for a stranger.

These inter-personal networks created a unique employee environment in which the chief executives exercise a kind of charismatic and authoritarian control through weekly

administrative meetings (8). Thus the real power was shared among the Executive Director, the Nursing Director and his assistant, and the Financial and Personnel Controller. The organization merely attempted to recruit those who would fit in, those who would get along well with others, and those who would not break the organizational rules. The professionals (eg., physiotherapists, social workers) who are in charge of departments have little influence over the policies or daily routines of the hospital. One department head said:

> The government gives little money to the hospital for maintaining the services. How could we compete? We just try to finish our 9 to 5 routine daily. It's essentially very peaceful at this place. Every department just does their own work.

Nevertheless, there seemed to be no real peace between the well-established departments and the newly developed ones. For instance, the physiotheraphy department (renovated in 1982) felt that the nurses were not very cooperative.

> They didn't appreciate our treatments and they complained about moving "their" patients around. It disturbed "their" schedules. So we can only treat the patients during the few hours before lunch and dinner. They require that we send all patients back on time. However, they seldom prepare the patients on time for us to pick them up.

I also found evidence of the chief executive's explicit control over paramedical departments (X-ray, laboratory,

occupational theraphy, physiotherapy). Most of the department heads were excluded from the weekly administrative meetings, and there was no worker's union. In addition, all paramedical departments were functioning at a minimum capacity. A large number of assignments like blood tests, X-rays, and physiotheraphy were referrals from the out-patient physicians or from private practitioners in the neigbourhood. Compared with other local hospitals, the paramedical departments at MCH were usually busy only half the day. This created an environment in which manipulation by a handful of chief executives was easily achieved.

The executives could also successfully excercise their administrative power vertically in the hierarchical scale. For instance, the executive director would call the president of the board of directors and the corporation at least once a week to discuss the "hospital's business." This suggests that the executive directors had the support of the hospital's organizers.

I interviewed several hospital organizers. Only one of them had a minor complaint. The others were satisfied with their performance in running the hospital. However, the corporation and the French Catholic administration were mutually dependent on each other. There was an understanding

that if it was not for the help of the French Catholics, there definitely would not be a modern Chinese hospital. All corporation members realized the important role played by the French executive team and their church during the negotiation process with the provincial government.

This also seems to explain the "segregation processes" among the founders, the French executives and the Chinese staff, since they were all placed together with these seeming different interests and favours. Hence, the rigid administrative control over different departments has granulated the hospital under the control of a few individuals.

Admission Problems

In relation to financial concerns, the executives were also anxious about the turn-over rate of in-patients at the hospital. Disposing of those in-patients who did not need any more intensive medical care, but also could not be discharged for personal reasons, had become the main problem of the admissions committee, which was composed of the Executive Director, the Professional Service Director (a Chinese surgeon), the Nursing Director, and the Social Worker. One of them said:

> We have a very long list, more than 200 patients, who are waiting for admission. Many of them do need intensive medical care. However, our-turn over rate is low!

Said another:

> We have tried different ways, we just couldn't get the families to come and pick up their relatives. We even promise them that they will have the first priority to come back anytime in case of any need. It just didn't work!

This "dumping ground phenomenon" has influenced the admissions policy of the hospital. "Seriousness of the illness, short term treatment, and poor home care facilities" were the first priorities for admission. However, admissions personnel also scrutinized the "intentions" of family members who sent the patient to the hospital: willingness to take the patient home when he/she no longer needed treatment was crucial.

All patients admitted went through a professional referal system. It was rare for the hospital to admit a patient with no connections with the hospital. The patients were either admitted through the out-patient department which they attended regularly, or through the hospital's attending or consulting physicians. An ex-applicant's relative said:

> My father-in-law suffered from sclerosis. He applied to that hospital for 2 1/2 years. He died at home

> recently. We have checked many times with the hospital. Just no space. Well, we know nobody there!

Such an admissions policy further reveals that the internal, natural organization of an institution always acquires features that permit the organization to evolve into a higher level, more complex system. This phenomenon also shows that the managerial team is fighting continously against the external environment since it is characterized by a relatively high degree of constraint.

THE BASIC TASK LEVEL

Introduction

Although various theoretical formulations have been used to account for the normative life in institutions, the meaning of the place, the language signs, and the roles of performers are the determinants for analysing the socially constructed reality. Goffman (1959) asserted the difference between "front stage" and "back stage" of a place and found that the back stage is the place where the team performers keep their secrets. Berger and Luckman (1967) stated that language is essential for any understanding of reality. It transcends the reality of everyday life altogether and gives meaning to one's behavior. Merton (1957) has defined roles

as constituting the primary focus of the articulation, and hence interpenetration between personalities and social system to connect culturally defined expectations of different individuals.

Definition Of The Place

Although the HCH is a small health care institution, the chief excutives do not appear on the wards very often. A floor staff said:

> The Executive Director only shows up with those big shots when they come for a visit or for an investigation. The personnel director thought that he has nothing to do with the patients in the ward. Only the Nursing Director would come up and do the rounds everyday.

However, in the minds of these core staff members, HCH provides excellent health care services to the community. It is a place of medical treatment and patient healing. They were enthusiastic about the hospital's overall work performance and proud of their contribution to patient care. Whyte (1956) preceived that organization men who not only work for the organization but belong to it as well have "taken the vows of organization life" and committed themselves to it.

At the intermediate level, staff saw the hospital as a more complicated combination of "little medical treatment," "nursing home," and "dumping ground." They did not share the ideology of their colleagues who were at the top. A registered nurse commented:

> You see, most of the people here can walk, can eat, can take care of themselves very well. They are just old! You know, when you are getting old, you start having all those common old age problems. The OPD physician just come to the ward and see each patient once a week, routinely prescribing some pills and tablets. Some of them don't even need any medication. They are here just because they have no other place to stay.

The occidental patients in the hospital found their stay at the hospital more enjoyable than did Chinese patients. They did not possess the sentiments that the MCH was the place where they would pass their final years of life. Rather they felt at home there. An ex-truck-driver said:

> This place is clean, all people here are nice. I can choose between the western and the Chinese food. There are many staff members whom I can talk to. My wife comes to see me every week. This is a very good place.

The Chinese patients felt they were being dumped there. They did not expect the hospital to be their final home until they got there. Patients who needed little or no medical treatment felt frustrated and angry.

> Our words are futile and meaningless. There is no such thing as 'like' or 'dislike' for us. If we do not like, what can we do? We are so old, everything has to depend on other people. Who still need us? If we are good [she means her fate] we wouldn't be here.

According to the staff, occidental patients in the hospital were more eager than the Chinese to participate in organized hospital activities (eg., outings or planning their own daily schedules). Most Chinese patients preferred to be left alone. On the other hand, most patients called their wards "rooms" in Chinese. They wanted others to know that they were different from the real patients. For instance, when they left their rooms, they would tell their wardmates that "I'm just going for a walk," or "I'm going to the T.V. room." Such behaviours indicated that these patients were behaving the same as if they had been in a private residence with shared living accomodations.

The Language, Signs, And Communication

In the hospital, French was the most commonly used language in most departments. Among the Chinese staff, Cantonese was the dialect used the most. However, most of the staff knew several Chinese dialects such as Toisanese and Mandarin. English and Vietnamese were also commonly used by some of the staff whose mother tongue was neither French

nor Chinese.

Among the Chinese patients, about 80 percent were Toisanese; only a few spoke English or Cantonese. Needless to say, most Chinese patients had communication problems with the staff, particularly with those floor staff who spoke only French (about 80 percent). In order to improve the communication gap, some Chinese in the ward voluntary taught non-Chinese speaking colleages some simple phrases like "how are you," "good morning," "good night," "taking medication." However, it was not effective; the patients did not feel encouraged and responded poorly.

On the other hand, some staff who spoke no Chinese had learned to understand the Chinese patients' needs by observing their "sign" language. They did this in two ways. The first was by observing the habits of individual patients. For example, some patients had the habit of going to the bathroom before going to sleep at night; some patients habitually demanded unreasonable things; some patients disliked the routine programs arranged for them; some preferred sitting in a wheelchair in the hall way each afternoon. The second way was to learn through the hidden meaning of the patients' gestures and the hints given by their "shrewd roomates." The majority of Chinese-speaking

patients had no intention or interest in communicating with non-Chinese speaking staff. Hence, often they would only use gestures to show what they wanted. Pointing at the door meant wanting to go out; drinking gesture meant thirst; an unpleasant facial expression meant pain. Among some patients who had lost the ability to control their hand motions, the signs and hints given by their "monitor roomates" became crucial. Essentially, all non-Chinese speaking staff acquired their ability to understand the needs of the Chinese patients by experience on the wards. However, it was not always this straightforward. A Chinese staff member recalled:

> In one shift, a Chinese nurse heard the bell ring from one of the bed-ridden patients. She sent a French aid into the patient's room; the aid came out in two minutes. Immediately, the bell rang again, the Chinese nurse [her former experience told her that there must be something wrong] went into the room right away and found that the patient has already bed wetted!

The cultural and language barriers caused the non-Chinese speaking para-medical staff to split the art of healing into 3 dimensions seperately,

> We know it is very difficult, and in fact it is impossible to know the psychological feelings and needs of the Chinese patients. However, as there are three different dimensions of patient care, though we do not understand the psychological and social perspectives of Chinese patients, we can still help

the patients by observing their bio-physiological conditions.

The communication gap extended to other departments. One patient complained:

> The person [the dietitian] knows no Chinese. I told her I couldn't eat hard rice not well cooked. The kitchen sent me more hard rice the next day. I told her again, I need a bit softer rice. They sent a bowl of porridge the next time.

Another part-time Chinese worker reported:

> It was the first day of my work in the hospital. I heard a patient screaming in Chinese. "The water is very cold! The water is very cold! I will die!!!... Don't wash my hair...very cold! very cold! No! No!

The French staff worker not understanding what the patient was screaming about, imitated the patient's verbalizations by making them into a song, which he repeated while he continued washing the patient.

I heard numerous complaints about the debilitating effects on the Chinese patients due to language difficulties: "Pain, hard to make them understand exactly where it is"; "asked for red tea, they brought me the Chinese tea"; "I don't know if they don't understand what I want or not willing to serve us." Nevertheless, the patients had become accustomed to such treatment. They believed "It's no use to tell anyone else."

At The Back Stage

Using Goffman's concept of the "back stage," I observed that the staff used patients' room and bed numbers instead of names as they talked about each individual patient. They classified the patients into distinct types. "Good patients" were those who needed no or little medical treatment and could take care of themselves. Usually these patients served as mediators between the staff and the Chinese patients who refused to communicate with the non-Chinese. An aid commented:

> S is a very good patient in this hospital. Besides her excellent workmanship [the hospital's occupational department teaches the patients to do art work] she never gave us any trouble, so all of us like her very much!
>
> S is a Canadian-born Chinese. Though she cannot walk, her mind is very smart. She is in charge of this room and help us a lot.

The "bad patients" or "jerks," as the staff sometimes called them had similar medical and mental conditions as the "good patients," but were neither submissive nor gentle. They often quarrelled, gossipped, and interfered with the staff's or patients' private business. They were there because they preferred "the home" to their own families. These patients generally had poor relationships with their families. They were also the main concern in the admission

committee. Then, there were poor patients." A Chinese nurse said:

> P has called his son and daughter-in-law many times and hopes that the family could bring him home for a weekend. Nevertheless, for the past few years, his dream has never come true. So he is always sad about this place.
>
> H is a very poor woman, she has lied in bed for many years. She worked very hard in Montreal and sent all her money back to China and applied for her children to come to Canada one by one. Now they all have their own business and family, but she is alone. No one comes to see her. I doubt the value of her self-sacrifice.

As Chinese culture upholds the virtue of piety, "dumping" senior members of a family in institutions and not visiting them is socially unacceptable behavior. Thus, it was not unusual for the Chinese staff to feel empathy for these "poor patients." I found there were only two to three families willing to bring their elder patients home on a regular basis. Some Chinese staff attributed this phenomenon to the westernization of the new generation of Chinese.

Task Orientation

Although the staff was aware of the patients' medical and social backgrounds, it did not affect the way they programmed their daily schedules. Hence, "breakfast-in-bed

without brushing their teeth" when the staff was busy, and "taking away the meal plates for slow eaters" was not uncommon. I noticed a woman in a locked highchair in the corridor. When I walked by, she asked me to bring her back to her bed. I spoke to two different workers about the request, and one said:

> It's not dinner time yet. Just ignore what she has said, we will bring her back before dinner is ready.

Below the Director of Nursing are head nurses who schedule day, night, and evening shifts. Since they are registered nurses (RN's), they are also responsible for filling out patients' charts, injections, and electrocardiograms. Their assistants take patients' pulse and temperature, and carry out other less important treatment procedures. The hospital allowed assistant nurses to distribute medications, which was not a regular practice at other hospitals. One ex-nursing assistant complained:

> I felt terrible and scared as they [the head nurses] asked me to go rounds with the cart [on which all medications were prepared and put in seperate small paper holders for each individual patients] and give patients medicine which I didn't even know what they were at that time. The practice was illegal and diffinitely not parallel to the training I received at school! So as they asked me to sign after each delivery, I was very reluctant, so I quit eventually.

The nursing aids (females) and the orderlies (males)

were responsible for taking care of the patients' bed-and-body work (eg., giving baths, wheeling them to the T.V. rooms, cafeteria, washroom, etc.). They had more face-to-face and hand-to-body contact with the patients than any other staff members.

Managing The Dying

Some staff on the floor called the dying patients [those who had no hope of discharge] "vegetables." Among the nursing staff, the word "vegetable" implied hopeless case, and, implicitly, it meant that any further treatment or care was a waste of time. The staff seemed more concerned with admitting a new patient than with saving an old one. The morale of healing and saving was low. One nursing assistant said:

> Since they [the patients] are all so old, what can we do for them? Our goal is to maintain their present health condition. If we achieve this, we have accomplished something.

After Bill 65, the hospital replaced the traditional white uniforms of nurses and the white bed sheets with "tidy regular coats and colourful bed sheets." White was normally associated with traditional funeral ceremony in the Chinese society. As there are no morgue facilities at the hospital,

the consulting doctor or the out-patient physician was called in case of emergency. If a patient died, the physician was urged to sign the death certificate immediately. The funeral home was called to pick up the body. In order to reduce the fear of dying among the other patients, the body was removed from the room as soon as possible. Empty patient rooms, out-patient department, or the laboratory sometimes became temporary morgues. As most deaths were anticipated, procedures were pre-arranged with the family, the nursing station, and the social worker.

However, pre-arranged procedures were sometimes difficult to achieve. Culturally speaking, the elderly Chinese did not like to discuss "arrangements" before their deaths. Wills were a source of problems both for the Chinese staff and family members. A social worker mentioned:

> Chinese patients have no sense of the law. Very few of them are willing to make a will before they die. Thus there are problems. Some patients have no visitors at all before they pass away. Later, some of their "relatives" might appear and asked for property left by the former patients. Some families might even force dying patients to sign the will prepared by themselves and ask the nurses as their witness.

Since the word "death" was taboo among the Chinese patients, relatives would tell their aged family members that they were looking for a place of "retirement" or

"rest." However, there was a latent understanding that the hospital would be their final home. The trip to MCH was a loop which implicitly hid all sorts of undesirable thoughts, tearful memories, pain, and sorrow for the elderly Chinese. The procedures through which they were processed meant making peace with an environment which was hopeless for them. However, for the chief executives, for the main hospital organizers, and for the goverment technocrats, the hospital's existence held a great meaning for their social roles and identities.

CONCLUSION

This chapter has summarized the political, cultural, and social changes which occurred in both the Chinese and the Quebec society in the 1970s, and their effect upon the development of the MCH. Direct government intervention through provincial laws shifted the power pattern of decision-making from the Chinese elites to a group of government technocrats. It also increased the conflict between the Chinese staff and the French Catholic administration in the hospital. All these interrelated changes blurred the functional role of the ethnic health care institution and resulted in apathy among its ethnic clients.

CHAPTER 7 CONCLUSION AND DISCUSSION

CONCLUSION

Some studies (eg. Aldrich 1979) assert that the expansion of state support and protection constitute an overwhelming advantage for organizations' growth and survival in modern societies. Other studies (eg. Krause 1968) suggest that government bureaucrats and reformers simply use public participation as a smoke screen to legitimate state intervention. As an ethnic health care institution, the HCH has struggled harder, and experienced more anxiety and uncertainty about its survival and growth since the centralization of the Quebec health care system in early 1960s than it did before. It has not been able to meet the expectations of either those self-appointed representatives of the ethnic community, or of the provincial government which has largely determined its goals and structures.

Few ethnic cultural elements have been able to permeate the hospital's organizational boundaries. This illustrates the state power of the dominant group--the host community--to enforce their own ideology and norms. Being

formally labelled as a chronic and convalescent institution, the hospital lost its charm of attracting trained Chinese personnel and of commanding resource to upgrade its services. (1) This has in fact contributed to the apathy of individual Chinese toward the services the MCH provided. It also helped to erode the relationship between the hospital and the Chinese community.

The hospital's own internal organization and ideology have had little impact on the external environment. Its survival and continuity has been largely dependent on government intervention, which in turn has threatened the autonomy of the hospital as an ethnic, health care institution. To cope with this strain, the MCH has put more emphasis on the institution than on certain needs of its patients. For instance, by recruiting more non-Chinese staff to perform the governmentally required technical tasks.

I have used an open systems perspective to reveal three key causal factors which have shaped the MCH: 1) the evolution of the Canadian/Quebec health care system; 2) changing structures in the Montreal Chinese community; and 3) shifting attitudes and demands of the Chinese toward western medicine. I have also shown that: 1) the minority ethnic group's disadvantaged economic, political, and social

position limited its financial, labour, and technological inputs to the MCH; 2) the Quebec health care system became more centralized at the expense of the MCH's charecters as an ethnic institution; and 3) there are limits to the ideology of multiculturalism when it conflicts with other policy interests.

DISCUSSION

In 1982, the MCH is Chinese in name only. The underlying issue in this study is the role played by the growth of a powerful government during the centralization of the Quebec health care system after the Second World War. Since the 1970s, Canadian health legislation provides all individuals, irrespective of ethnic origin and social class, with basic health services, though the quality of medical care is not equal for all groups (Riessan 1974). It can be argued that this policy hinders the free play of the health care system by limiting the development of such institutions as the MCH, and directly and indirectly restricts people's freedom to choose on various treatments such as traditional Chinese medicine. Johnson (1979) has argued that state intervention has the effect of placing power in the hands of technical "know-hows" and creates large scale bureaucratic

service agencies. Efficiency becomes a crucial if not unique yardstick in determining the value of existence of organizations.

In a modern democratic society, governments are intended to act on behalf of the population and protect them from the manipulation of large, private-interest groups. However, as this study has shown, in a pluralistic society, state intervention can generate conflict between the service demands of a minority ethnic group and administrative demands of a centralized, bureaucratic system. Thus, one could argue: the rights of the Chinese minority in Montreal have not been well served. As a marginal ethnic group in Quebec, some of its needs and preferences have conflicted with those of the host community's policy makers. Western medical science and health care systems have evolved through specific economic, technological, and social conditions. Chinese traditional medicine which has existed for thousands of years, is an association between a well-developed Chinese philosophy and herbal medicine. Thus, an "ethnic lag" has existed--and continues to exist--particularly among elderly Chinese and newly arrived immigrants.

I have no intention of judging the quality of care which the MCH has provided. It is difficult to measure its

performance due to the difficulty in defining performance criteria and selecting measurable attributes (Brook et al. 1977; Ver Steeg and Croog 1979; Scott 1981). Even at the organizational level, it is difficult to decide if the hospital has been doing something "to" its clients, or "for" its clients, or "for" advancing the interests of the hospital organizers and staff. I do believe, however, that since federal and provincial governments uphold multiculturalism and the rights of minority groups, the policy makers must respect and recognize different ways of life and needs in planning the health care system.

In theory, a small, ethnic hospital should be able to adapt to the culture it is serving and make its patients feel as if they belong to the healing environment. It should be able to fill a role which the regular general hospitals cannot hope to provide. However, an ideal ethnic hospital does not seem to be possible within the mainstream health care system. (2) As one of the chief staff members at the HCH said,

> It's difficult for a small ethnic health care institution like us to follow all the regulations, standards, and requirements like the Royal Victoria Hospital. For we don't have enough manpower and facilities to run exactly like those big hospitals. For example, we have to elect our Board of Directors exactly according to the government's hospital

> regulation. It doesn't make any sense to us. However, we have to, for it's the law which we have to follow.

Many studies, including Bullough and Bullough (1982), Harwood (1981) have provided detailed information on the health beliefs and behaviours of ethnic minority groups. Twaddle (1968) stressed that ethnicity helps to define the core concerns of the various subcultures. These concerns lead to ethnic differentials in the rewards and costs attached to illness, and differences in illness behaviour as well as differences in status designation. An anecdote related to me by a Chinese staff worker demonstrates the significance of cultural variables:

> This patient was transferred from a French hospital; she was diagnosed as in a "serious" confused state when she was sent here. But we see her as perfectly normal....We know its the language problem; for she speaks neither French nor English, Toisanese is the only language she uses. Gaps in communication create all sorts of problems, even in this hospital.

It is important to humanize health care and protect elderly, chronic, ethnic patients from the bureaucracies which want to "process" them. As this study has shown, centralization has forced the MCH's organizers and chief executives to fight constantly for the survival of their hospital, rather than focus their attention on the more subtle ethnic aspects of quality of care. In fact, their powers are restricted by government control, and many

patients have paid a very high price for the survival of the institution.

As Freidson (1975) argued, quality care is not acheived by technology alone: it is achieved primarily through organization i.e. the pattern of relationships influences the content of interaction, independently of the individual characteristics of the participants. According to him, the value of any formal social policy is to be found in the settings of everyday life rather than in the highly selective abstractions of the statistics, accounting devices and indicators found in official documents. Official documents do not merely report the activities of workers; they are created by them with their own purposes in mind.

Many studies, including Sung (1967), Wu (1975) and Carp and Kataoka (1976), have shown that elderly Chinese have received some of the worst health care in North America. They comprehend neither western culture nor the bureaucracy of the health care system. As a result, they have suffered a loss of status and have been frustrated and depressed. This study is consistent with their findings. The lack of health care policies explicitly oriented to ethnicity in Canada offers no hope for the elderly Chinese population in the foreseeable future.

Toomey (1970, 39) observed: "The fascination of the health care field is that there are better ways of financing and delivering services, but history, tradition, power struggles, political and economic theories, and other non-health factors keep the field from performing as it should." This is particularly true in Quebec, where the production and distribution of medical services remains largely in the hands of government technocrats and physicians. Because medical care expenditures continue to escalate, resources are not likely to be channelled into services for the special needs of disadvantaged groups.

Sills (1968) points out that large political structures discourage the formation of voluntary associations in deprived subcommunities, and that when they do exist, such associations actually serve as "passageways for withdrawal" from the exercise of real power. Ethnic organizations which function in this way may be seen as helping to bolster class control by charter ethnic groups who remain over-represented in the elite structures (Porter 1976). Breton (1981) showed that most Chinese in Toronto were pessimistic about the ability of their own community's decision-making structures to deal with their problems and to bring about change. The social history of the MCH lends support to this finding, and questions the present possibility of implementing the

Canadian ideology of multiculturalism. It also questions the efficacy of Quebec's social policies stressing community control, and their implication that ethnic voluntary organizations can serve as mechanisms for solving ethnic social problems.

Government technocrats may have special expertise in the technical aspects of medicine and of running the health care system. They do not have special expertise in the needs of their ethnic clients. Instead of paying lipservice to multiculturalism and to the notion that all ethnic groups are equal and deserve equal recognition, policy makers need to show more genuine recognition and acceptance of these principles in providing health care for people of different ethnic backgrounds. The social history of the MCH suggests that more careful consideration needs to be given to the social dimensions of medicine for ethnic groups in the Canadian context. For instance, let the minority groups be involved in the actual planning of care delivery.

Foot Notes

Chapter 1

1. The federal Multicultural Act of 1971, and the subsequent activities of the multiculturalism directorate of the secretary of state, recognize the value of minority group cultures and seek to assist minority groups to retain and enhance these cultures. Quebec, while known more for its French unilingualism and nationalistic posture, has likewise recognized the value of cultural minorities in the province, through its white paper on culture (see Ch. 3 volume one, A Cultural Development Policy For Quebec / Quebec Government: 1978) and the Ministry of Immigration and Cultural Communities.

2. In Gordon's (1964) Assimilation In American Life , the term cultural assimilation refers to a change in the cultural patterns between an institution and its host community. Structural assimilation refers to the large-scale entrance into primary group association of the host society. Others types of assimilation are: marital assimilation, identification assimilatin, attitude reception assimilation, and behavior reception assimilation.

3. I use perspective rather than "theory" to describe this system. "Theory" has been thought to be overused in recent years (eg. P. Caws (1968). "Science and System: On the Unity and Diversity of Scientific Theory". In General Systems Yearbook , No. 13, PP. 512; C. Perrow (1970) Organizational Analysis: A Sociological Perspective Calif.: Wadworth Publishing Co., Inc.; Richard Hall (1979): Organizations. New Jersey: Prentice-Hall Inc.) The open systems perspective provides a set of useful concepts and working hypotheses for studying the basic similarities believed to exist among certain properties of all systems.

4. The approach has been widely used across a broad spectrum of disciplines, including the natural, physical, applied, and social sciences. It provides a body of organized theoretical constructs which can be employed to discuss relationships observed in the empirical world. For a good review of its applications, see "General Systems Theory--The Skelton of Science", by Kenneth Boulding. In Modern Systems Research For The Behavioral Scientist. Walter Buckley edited. Ill: Aldine Publishing Company, PP. 3-10. 1968.

5. The notion of "general systems theory" is generally attributed to the biologist Ludwig Von Bertalanffy, who introduced it in the late 1940's. The approach has been

promoted and further developed by Boulding (1956), Buckley (1967, 1968), Kuhn (1974), and Scott (1981). For a fruitful and complete integration, see Katz and Kahn (1966, 24-29, 59-62).

6. Parsons (1960) has distinguished among institutional, managerial and technical systems as the three major hierarchical levels fulfilling different functions in organizations. In Structure and Process in Modern Society Glencoe, Ill: Free Press.

7. Perrow defines technology as "a technique or complex of techniques employed to alter 'material' (including human) in an anticipated manner". See 'Hospital: Technology, Structure, and Goals', in Handbook of Organizations J. March ed. (1965, 915). Chicago: Rand McNally. J. Thompson noted that technologies and the environment are basic sources of uncertainty for organizations. New York: McGraw-Hill (1967, 13)

8. J. Thompson and W. McEwen (1960) have paid explicit attention to competition in the social environment of organizations. It includes a range of process, e.g. scrambling for resources, for customers or clients, as well as for potential members and their loyalties. See

"Organizational Goals and Environment", in Complex Organizations: A Sociological Reader A. Etzioni ed. New York: Holt, Rinehart and Winston, Inc. PP. 177-186.

9. Michel Brunet has used the same approach to study the evolution of a religious organization for his M.A. thesis in 1975 written under the supervision of Prof. Joseph Lella in the Department of Sociology, McGill University.

10. Apart from Scott (1972), Mayans (1966), Georgopoulos (1962, 1972, 1975), Neuhauswrn and Anderson (1972), Steeg and Croog (1979) have also examined hospitals using this concept. Caudill (1958) analysed hospitals as small societies in which administrative processes directly affect patient behavior. Parsons (1960) looked at hospitals as complex social systems for optimizing gratification functioning with, and in relation to, a total society.

Chapter 2

1/ According to Lee (1967, 36), before 1860, Chinese only came to Canada through United States. There was no direct immigrants from China. From 1858 to 1859, about 2,000 Chinese arrived at Simon Fraser, B. C., to join the gold rush from California; there were about 30,000 Chinese there

then.

2. Many of these males were "married bachelor," that is, they were married before they left China for North America. However, immigration laws prohibited the entrance of spouses and families except for those few who had been granted "merchant" status.

3. Rev. Thomas Tam, Father of the Chinese Catholic Mission of Montreal, provided this information from the manuscripts of a late Canadian Father who had worked among the earliest Chinese immigrants in Montreal.

4. I have found that most Chinatowns in North America are situated close to the railway stations and are abandoned downtown areas. According to many old Chinese American and Canadian immigrants, this was due to two main reasons: 1) Chinese migrated by railway, looking for towns with good job opportunities; 2) once settled, and in order to save transportation expenses, they usually lived within walking distance of their working places. Many elderly Chinese Montrealers reported the same case.

5. These clans and district associations are inclusive, in that all people with the same family names or from the same

villages in mainland China were members regardless of social status. They are exclusive in that people with different family names or from the different districts are not allowed to participate. These social organizations have a tremendous effect on labour recruitment in the ethnic market (ie. Chinatown's business). Many Chinese in Montreal and other cities say "you only found jobs through clans and district associations connections in the early years (before the SecondWorld War), for all laundary shops, groceries, and restaurants were all family business. In fact, even today, there are only very little changes," a retired laundry man reported.

6. This system consisted of a group of close friends and relatives pooling their resources to meet one anothers' urgent needs.

7. Abraham Flexner studied the medical education in the United States and Canada. His work was recognized as the impetus for revolutionary advances in the training of modern physicians.

Chapter 3

1. According to McGinnis (1977) and others, this epidemic

affected 40 percent of the world's population and killed about 22 million people. In India, 12 million people died; in the United States, 675,000.

2. A kind of herbal tea, consists of 24 plants, popular in southern China, homeland of the immigrants.

3. The exact starting date of the Chinese Association (the Chinese Benevolent Association) in Montreal is unknown. Sources say it existed informally a few years before the Montreal Chinese Hospital was born in 1918. It appeared as a formal organization in 1920 when the community purchased a three storey building in Chinatown. The first two floors and and the basement were used as the hospital's permanant address; the top floor was given to the Montreal Chinese Association.

4. Apart from respecting the parents and elderlies, Chinese culture also emphasizes "seeing the dead persons away comfortably. According to Lee (1967, 221-224), between the 1889 and 1937, Chinese immigrants in Canada arranged the transportation of bones back to China via Vancouver every seven consecutive years.

1. According to statistics from the Commission of Overseas Chinese Affair of Kwangtwung Provincial Government, about 30 percent of overseas Chinese families owned land; thus, they were "landlords." The government considered money remittances from overseas relatives as "fruits of fendalistic exploitation in order to increase the number of landlord elements in their districts (Lu 1956, 27).

2. The Chinese government regarded the overseas Chinese as "fruits of fendalistic exploitation." They expropriated their properties and lands, and oppressed their relatives. Many "residual" Chinese in North America were strongly anti-Communist. The attitude only started changing in the late 1960s as the regime in mainland China gained a better reputation, and the number of Chinese immigrants in North America proliferated due to the abondonment of discriminatory immigration laws.

3. For chinese banking system, see chapter 2, footnote 6.

4. Although Chiang (1978) used systematic random samples in the study, the educational levels she found were extremely high. Nevertheless, the conflict between the old elites (clans and district association leaders, Chinatown entrepreneurs) and the young elites (mainly highly educated

professionals) have been obvious since the 1960s. They competed for government grants for running cultural activities, competed for clients for the services they provided and competed for leading positions as Chinatown representatives.

5. The phenomenon revealed the ethnic conflict which has existed between the Han and Moon groups since the end of nineteenth century. In fact, the conflict among ethnic groups in mainland China still exists today (eg. between Han and Tibetan), though it is not as obvious as we see in North America.

Chapter 5

1. According to many old Chinese and priests, many Chinese in Montreal died at their middle ages due to poor living environment, overwork, and delayed consultation with a doctor.

2. The mother house is an active Catholic mission. They send missineries abroard, and build hospitals, schools, and other social service organizations all over the world.

Chapter 6

1. Although this is only an estimate by community leaders, it is quoted frequently by local newspapers, social service agencies etc. The actual figure is probably lower. The exact figure from the 1981 census will be available in spring 1984.

2. According to herbal practitioners, larger Chinatowns such as those in New York and Toronto have close to 100 formal (affiliated with a herbal shop) and informal (practitice at home, clients are referred through social networks) Chinese herbal practitioners. "Due to the fact that patients there are not free for services under the health care system, those Chinese practitioners are well visited. Their services are one of the rational choices for the Chinese." one of them noted.

3. This figure were estimated by reliable informants (by counting the the number of clan and district associations, golden age clubs, and other traditional social organizations in Chinatown). One organizes about two to three groups for its participants. Members contribute either $10, $20 or $30 a month. The practice is still quite propular among elderly and middle-aged Chinese, especially those who work in the ethnic labour market and those who have close connection with Chinatown business.

4. Many community leaders have expressed concern and suspicion about the city government's intention in the future of Chinatown (see CIDEM 1983). According to my interviews with community leaders, many Chinese were inactive and apathetic in federal and provincial elections. However, during the 1980 Quebec referendum on independence, many family groups voted for the Liberal party against the issue.

5. According to Tzuk Y. (1982) Jewish Communal Welfare Institution In A Changing Society Unpublished Ph. D. thesis, Department of Religious Studies, Concordia University. Only the Jewish Family Services-Social Service Centre (JFS-SSC) retained control under government intervention due to the unique cultural-linguistic criterion and the recognized high standards of professional services provided by JFS and the respect of Quebec government toward the Jewish community in general and the Jewish welfare agency in particular.

6. Under regionalization, sectarian and religious health and social welfare organization either "going public" or closing down. For downtown obstetric service, all were being concentrated in three general hospitals. They were Jewish General Hospital, Saint Mary Hospital, and Royal Victory Hospital.

7. According to my 1983 study, the percentage of Chinese employees has gone up to about one third of the total employees in the hospital as the new reception centre beside the hospital opened its service in December 1982.

8. According to para-medical department heads, the weekly administrative meetings excluded their presence. Only directors and co-ordinators (eg., of professional services, nursing) are allowed to attend. Individual departments request has to pass the section director first before it can reach the top executives.

Chapter 7

1. I have formally and informally interviewed many Chinese medical and para-medical professionals (including trainees and students) in Montreal and found that many of them were not interested in working or having their internships in the MCH because of the institution's chronic nature. Very few were exceptions.

2. It is important to clarify that I am not arguing for the provision of ethnic social institutions for all ethnic groups (eg., for education, health services) in the Canadian context. Obviously, the society has only limited resources.

This thesis just scrutinized an already existing case and revealed that the MCH was at one time the object of sacrifice for constructing the legitmated reality.

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Appendix A: Old and New Locations of The MCH

Appendix B: Old Hospital Budget vs New Hospital Budget

(a) As The Old Hospital In Chinatown

Revenue

Grant-Quebec Hospitalization	$ 29,354.50
Old Age Security Pension	10,980.00
Dispensary and Welfare Service	4,979.50
Donation Received	25.00
Interest On Deposits	85.88
Total	$ 45,424.88

Expenditure

Drugs	$ 3,752.11
Food	7,757.71
Hospital Supplies	751.49
Salaries For Doctors	2,620.00
Sisters of Immulate Conception	9,096.00
Employees	14,392.38
Repairs and Maintenance	2,197.30
Heating	1,358.29
Laundry	1,992.29
Legal and Admit Fee	2,725.00

Electricity	1,245.76
Telephone	834.40
Subscripture	245.40
Stationary and Office Expenses	948.20
Taxes	549.18
Insurance	60.00
Total	$ 50,525.51

Source: Abstracted from The Auditor's Report (1964)

(b) As A Non-Sectarian Hospital In Jean-Talon Revenue

In-Patient Department

Provincial Plan	$ 280,806
Public Charity Act	33,021
Private & Semi-private Patient	9,398
Custodial	14,879
Non-Residents	1,184

Out-Patient Department

Provincial Plan	$ 30,956
Board	73
Other	5,184
Bad Debts Recovery	29

Other Income

Donations	$ 1,974
Dietary	4,759
Housing	2,848
Total	385,111

Expenditure

Administration	$ 56,705
Dietary	49,676
Laundry	9,200
Linen Services	7,329
Housekeeping	32,163
Maintenance & Repair	187,451
Laboratory	14,687
Radiology	14,322
Physiotherapy	9,475
Medical Record	2,823
Social Service	672
Nursing Department	144,958
Out-Patient Department	1,357
Central Supply	7,796
Pharmacy	5,403
Delivery Room	29,184
Total	418,128

Source: Abstracted From The Auditor's Report (1968)