

**RACE, HOSPITAL DEVELOPMENT AND THE POWER OF COMMUNITY:  
CHINESE AND JAPANESE HOSPITALS IN BRITISH COLUMBIA FROM  
1880-1920**

by

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## **Abstract**

Although much is known about the development of general public hospitals in Canada during the turn of the twentieth century, little is known about the rich diversity of smaller community hospitals founded during this time period. From 1880 to 1920, there were at least 155 hospitals operating in British Columbia, including several Chinese hospitals, founded in Victoria, New Westminster and Vancouver, and a Japanese hospital in Steveston. These hospitals were established in a context of harsh economic, political and social restrictions for Asian populations. Yet, Chinese and Japanese hospitals developed differently because of important cultural and political differences within Canada and abroad. An initial overview of Chinese hospital development reveals that Chinese hospitals mimicked charity hospitals found in China at the time and utilized Chinese, rather than Western medicine. In contrast, the Japanese hospital, which is the primary focus of this study, was built as a ‘modern’ hospital and utilized Western scientific medicine and trained nurses. Analysis of primary and secondary sources, including two newly translated Japanese histories, demonstrates that local communities played a significant role in the development of Asian hospitals. The Japanese hospital in Steveston, for example, began as a modest Japanese-Methodist mission hospital, established by Japanese Christian missionaries themselves. As hospital debts mounted and the anti-Asian labor movement intensified, Japanese leaders endeavoured to convince the Japanese fishermen’s Benevolent Association to build and finance a new modern hospital. Over time, the hospital became closely tied to the changing needs and prosperity of the local Japanese fishing community. The hospital was utilized as a source of leverage for Japanese fishing leaders during fishing price negotiations. From the unique perspective of community leaders, the hospital became an important political tool in the fight for racial and economic equality. This study reveals that Asian hospitals were much more than institutions for restoring health or curing illness. Chinese and Japanese hospitals were grassroots community initiatives that not only met important local and cultural needs, but could also play an important role in broader issues of social justice.

## **Preface**

This dissertation is original, unpublished, independent work by the author, Helen Vandenberg.

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*To the Pioneers of the Japanese Hospital*

## INTRODUCTION

Much of what is currently known about hospital development in Canada during the turn of the twentieth century focuses on the development of large public general hospitals.<sup>1</sup> Researchers like David and Rosemary Gagan, who have studied the history of these hospitals in Canada from 1890 to 1950, outlined how hospitals have transformed from charitable care of the poor and needy to modern scientific institutions.<sup>2</sup> Their work has tended to focus on the experiences and perspectives of doctors, nurses and patients. Similarly, scholars of nursing history have examined the hospital from the perspective of nurses, with a particular focus on the professionalization of nursing and introduction of various training models.<sup>3</sup> Yet, little is known about the myriad of diverse smaller hospitals that were established during this time period.

From 1880 to 1920 alone, over 155 hospitals were built across British Columbia, including several Asian hospitals.<sup>4</sup> Chinese hospitals were established in many of the province's burgeoning towns, including Victoria, New Westminster, Vancouver and Kamloops.<sup>5</sup> Additionally, two Japanese hospitals were built in the bustling salmon fishing village of Steveston.<sup>6</sup> The first Japanese hospital began as a make-shift mission hospital (operating from 1896 to 1899), until a larger Japanese fishermen's hospital was built in 1900. This larger hospital operated under the control of the fishermen until the internment of the Japanese during WWII in 1941. Local Asian communities played a central role in establishing and operating Chinese and Japanese hospitals in British Columbia at the turn of the twentieth century.<sup>7</sup>

In contrast to what is known about the history of large general public hospitals in Canada, Chinese and Japanese hospitals were smaller, community-driven hospitals that employed a professional staff in ways considered quite different than what is generally depicted during this time period. For example, many early Chinese hospitals relied on a lone-male Chinese caregiver

and trained, professional nurses were not utilized until well after the 1920s.<sup>8</sup> The Japanese hospitals, on the other hand, utilized Japanese volunteer male missionaries as nurses in addition to trained physicians and professional nurses.<sup>9</sup> Yet Western-trained medical professionals were not responsible for initiating the development of the Japanese hospitals in Steveston. The brainchild of these hospitals originated from Japanese community leaders themselves, including Japanese Methodist missionaries, the Japanese Consul and the heads of the Japanese fishermen.<sup>10</sup>

Chinese and Japanese hospitals emerged within the colonial context of a dramatic population explosion (1886-1914), where hundreds of thousands of primarily European immigrants came to settle in the new British colony.<sup>11</sup> Asian workers also arrived, encouraged by wealthy capitalists as a source of cheap and plentiful labour. Chinese and Japanese immigrants were fundamental to the economic prosperity of the newly established colony, but they were not treated as citizens equal to most European settlers.<sup>12</sup> They faced harsh economic, political and social restrictions, and as a result formed separate insulated communities. The most affluent leaders of Chinese and Japanese communities established community associations to enhance the status of Asian immigrants and to resist racism and discrimination.<sup>13</sup> These community organizations, termed Benevolent Associations, became responsible for the development of the first Asian hospitals in British Columbia.

Though all Asian populations in Canada were constructed as outsiders and marginalized by the dominant White society at the turn of the 20<sup>th</sup> century, Chinese and Japanese hospitals developed differently from each other because of important cultural and political differences within Canada and abroad. During the mid-1800s, both China and Japan faced Western imperialism via military defeats and subsequent ‘unequal treaties’ imposed by Western nations during the mid-1800s.<sup>14</sup> Western imperialism was handled differently by China and Japan during

this time period. China faced Western domination by promoting anti-foreign dogma and entering a period of isolation and self-strengthening.<sup>15</sup> Japan, however, began a campaign of modernization and militarization, with the aspiration that they would eventually be able to negotiate the terms of future relations.<sup>16</sup> The actions taken by Japan and China during this time period influenced how Chinese and Japanese communities functioned in Canada, including how they created and accessed health care services.

Similar to the early Chinese hospitals of San Francisco (1870s & 1880s), the first few Chinese hospitals built in Canada's Pacific Northwest likely mimicked charity hospitals found in China at the time.<sup>17</sup> These hospitals were small, modest operations that provided basic shelter, food and Chinese, rather than Western medicine. Chinese hospitals faced more public scrutiny than other hospitals because Chinese communities were accused of spreading infectious disease.<sup>18</sup> Even if Chinese community leaders desired to improve the status of their hospitals, they often did not have the support and means to alter services.<sup>19</sup> Chinese populations were more vulnerable than Japanese populations to public scrutiny because the Chinese government had less political or military influence to resist Western dominance.<sup>20</sup> For example, exclusionary measures were approved by the Canadian federal government as early as 1885 because the Chinese government could do little to resist such policies, and Canadian officials regarded China as a weak nation.<sup>21</sup>

In contrast, the Japanese government maintained a strong connection with the Japanese community in British Columbia to protect Japanese citizens from proposed prejudiced local and national policies in Canada. The political influence of the Japanese government began considerably earlier than China's partly because they established a consulate in Vancouver in 1889, and also because Japan had gained a reputation as a military power and modern nation

among Western countries. As a result, Japanese immigrants were able to freely enter into Canada until tensions came to a head between White and Japanese workers in Vancouver in 1907. Due to the influence of the Japanese government, the Japanese consulate was able to negotiate a ‘Gentlemen’s Agreement’ with the Canadian government whereby only 400 Japanese men were allowed to enter per year from 1908 to 1927.<sup>22</sup> This number was reduced to 150 per year in 1928, and Japanese immigrants were restricted altogether during WWII when Japan joined forces with axis powers Germany and Italy.<sup>23</sup> Chinese immigrants, on the other hand, faced substantial head taxes beginning in 1885, and were required to pay \$50 upon arrival in Canada. The tax was increased to \$500 in 1903,<sup>24</sup> and with a few exceptions, Chinese immigration was almost entirely prohibited by the Chinese Exclusion Act of 1923.<sup>25</sup>

In light of the early prejudicial policies faced by Chinese populations in British Columbia, Japanese leaders in Canada, including the consulate, resolved to continue to differentiate themselves from their Chinese cohorts. In 1900, the Japanese hospital in Steveston was built as a ‘modern’ hospital, utilizing Western scientific medicine and trained nurses. Influenced by the success of modernization and militarization campaigns in Japan, the Japanese community in British Columbia was able to use Western ideas as a way to resist racist attitudes and policies. The modern hospital was utilized as a powerful symbol to support the notion that the Japanese ought to be considered naturalized citizens in Canada. In this way, the history of Chinese and Japanese hospital development in British Columbia demonstrates that hospital development in Canada was shaped by cultural and political relations, both abroad and at home.

Both Chinese and Japanese hospitals eventually utilized Western medicine and trained nurses, however, their approach was not a straightforward adoption of dominant models of nurses training and hospital work at the time. The political, economic and cultural context shaped

the way nursing care was employed. For example, male Japanese workers were identified and utilized as nurses for the early mission hospital, despite being untrained and inexperienced. Although there were few primary sources about the presence and work of the hospital's nurses, the sources that were available allowed an intriguing window into the way local Chinese and Japanese communities' actualized hospital care within a context of overt racism. As such, this study interrupts dominant views and historiography rooted in the modernization of nursing and hospitals, which primarily focus on White and Western models of nursing care.<sup>26</sup> Some nursing scholars have begun to expand upon this focus by exploring, for example, the history of Black nursing in Canada<sup>27</sup> or Japanese midwifery in the United States.<sup>28</sup> This study provides a first glimpse into the way Chinese and Japanese communities in Canada adapted hospital and nursing care during the turn of the twentieth century.

In this study, I pay attention to the role of culture and race in shaping the development of hospitals in British Columbia. For instance, I examine how racially marginalized groups utilized hospitals to meet the needs of their own communities. Anti-Asian rhetoric prompted Chinese and Japanese populations to establish Benevolent Associations to protect the interests and health of their respective communities. Asian groups were accused of maintaining poor living conditions so that the majority of their earnings could be used to support family back in home countries.<sup>29</sup> It was argued by the broader White community at the time that Asian groups were incapable of assimilation and unworthy of citizenship.<sup>30</sup> Those who utilized this line of reasoning helped incite discriminatory policies related to immigration, citizenship, enfranchisement and employment. In this study, I argue that despite this context of racism, Asian communities were able to develop hospitals that were integral to early Canadian health care. Local Asian communities pooled resources to develop hospitals, and in the case of the Japanese hospital,

hospitals debts were used an important source of leverage for Japanese leaders to obtain more equitable fishing prices. This study demonstrates that the Japanese hospital itself was utilized a tool to promote social justice by enhancing both economic and social equity.

The organization of Chinese and Japanese health services was shaped by a context of overt racism, but ultimately Asian hospitals themselves were not created because of forced exclusion, as has been observed in the United States regarding the history of several segregated Black hospitals.<sup>31</sup> Rather, primary sources reveal that Chinese and Japanese hospitals were developed via community activism, with the idea that these services would provide health care that would meet the social, cultural and language needs of the newly forming Chinese and Japanese communities in British Columbia. Although Chinese and Japanese populations did have access to British Columbia's large public general hospitals, like the Vancouver General, there was a great desire among these populations for hospitals that would be developed and controlled by Asian communities.

Religion was another important concept of analysis discussed in this study that shaped Asian hospital development. During the turn of the twentieth century, both Catholic and Methodist missionaries built hospitals that served the needs of non-White groups in Canada. Christian doctrine inspired followers to engage in charitable works, including education and health care.<sup>32</sup> The missions that were initially aimed at Aboriginal populations, created a basis for the ideas that guided the work with all non-White groups.<sup>33</sup> Missionaries viewed these groups as part of obsolete or declining civilizations in need of Christian conversion and assimilation.<sup>34</sup> Yet, the types of medical missionary work undertaken amongst Aboriginal,<sup>35</sup> Chinese<sup>36</sup> and Japanese<sup>37</sup> populations in British Columbia differed greatly. Japanese populations were amongst the few groups to actively become Methodist missionaries themselves and control the

development of their own churches and hospital prior to the 1920s.<sup>38</sup> Overall, Christianity offered non-White groups opportunities to participate in aspects of Canadian life, like healthcare, that otherwise would have been difficult given the prejudiced context of the time. For example, Japanese Christian students with an interest in medicine were often given employment at the hospital as nurses or support staff.<sup>39</sup>

### **Context for the Study**

The communities that developed Chinese and Japanese hospitals during the turn of the twentieth century were shaped by important political, economic and social conditions in British Columbia. During this time, the population underwent a significant period of change and growth. According to historian Jean Barman it is estimated that there were between 80,000 to 200,000 Indigenous people before outsiders arrived.<sup>40</sup> There were several different Aboriginal groups and those living on the West coast comprised at least half of Canada's Indigenous populations. Aboriginal communities differed in social organization, yet all shared the goal of living in harmony with the land. There were complex local economies and trading networks that would be severely interrupted by the arrival of explorers hoping to lay claim to the land.<sup>41</sup>

From 1785 to 1825, explorers from Russia, Spain, England and the United States all took interest in British Columbia at various times. However, most interactions were limited to sea trading of furs and other goods. Land exploration did not become a serious endeavour until several forts were established and small colonies began to form. On June 15, 1846, Britain and the United States signed the Washington Treaty which set the boundary between Canada and the United States at the 49th parallel. It was at that time Britain laid claim to the area.<sup>42</sup>

In 1849, Britain gave the Hudson's Bay Company ownership of the Vancouver Island colony for five years. However, the company had to agree to attract enough British immigrants

to establish a small settlement. Parcels of land were sold for £1 in exchange for the building of infrastructure like roads, schools and churches. It was during this time that the fur trade began to decline as the trend for fur fashions decreased in Europe. As a result, mining, lumber, and farming industries became key industries. At the time the Victoria colony had about two hundred non-Indigenous settlers, while about 350 lived on nearby farms, there were 150 in Nanaimo and several more scattered at Fort Rupert, New Caledonia, San Juan Island and in the interior at Fort Langley and Kamloops.<sup>43</sup>

In 1858, the gold rush drastically altered the racial make-up of British Columbia. About 30,000 immigrants came to the mainland in search of gold, including many from Europe, the United States, Asia and other countries. The influx also ended the exclusive control of the Hudson's Bay Company. In 1871, British Columbia officially became a province as it joined Canadian Confederation.<sup>44</sup>

During the 1860s and 1870s, Confederation was still in its infancy and inhabitants of British descent endeavoured to dominate British Columbia socially, politically and economically. British colonists utilized non-White workers as a source of cheap and plentiful labour. Asian workers in particular, were recruited by wealthy capitalists to work for less money than their White counterparts in railway, mining, forestry and fishing industries. At this time, the province was not yet a social welfare state, and the government did very little to interfere with the laissez-faire businessmen who pursued their own self-interests. The three largest groups to arrive in British Columbia from Asia were Chinese, Japanese and South Asian (primarily Sikh) men. Despite being characterized as homogenous ‘Orientals’ by many White British Columbians, the experiences of immigration and colonization differed greatly among these groups, and it was only Chinese and Japanese populations that established hospitals on Canada’s West Coast.<sup>45</sup>

Chinese immigrants were the largest group to work in British Columbia during the time period under study. They first entered Canada from California in 1858 during the Gold Rush in Northern and Eastern British Columbia. Those who came from California had been in North America for roughly 10 years, and two years later hundreds of immigrants entered directly from China, increasing the number of Chinese migrants to about 1,500.<sup>46</sup>

As Chinese immigrants settled in the province, they became well-known for being industrious and took every possible work opportunity in the new economy. They reworked abandoned mining sites,<sup>47</sup> established laundries, restaurants and farms to service the populations of primarily male workers in Canada.<sup>48</sup> Chinese workers also took advantage of the newly established salmon canning industry, dominating much of the indoor cannery labour. As more British families settled in the province, Chinese laborers worked as servants and houseboys.<sup>49</sup> Only a few elite Chinese families settled and established businesses in the Pacific Northwest.<sup>50</sup>

During 1881 to 1884, 17,000 Chinese labourers came to British Columbia, the majority of whom came to work on the Canadian Pacific Railway.<sup>51</sup> Most workers came from eight rural counties in Southern China, in Guangdong province, located on the Pearl River.<sup>52</sup> They arrived not only to take advantage of the promise of fortune, but also to escape economic hardship, internal strife, and the Opium Wars in China.<sup>53</sup> Chinese workers who left China to find work in Canada, often faced hardship and marginalization. For example, in British Columbia's mining industry, White miners criticized Asian workers for a lack of ability to speak English, ignoring safety standards and refusing subservience.<sup>54</sup> Anti-Asian Labour exclusion leagues were formed by White workers and they called upon the provincial and federal government to eliminate Chinese immigration. However, the federal government refused to legislate anti-immigration

measures until after completion of the railway, demonstrating that Asian labour was fundamental to the completion of such projects.<sup>55</sup>

These events had a significant impact on the way that Chinese populations developed hospitals and health services in British Columbia from the 1860s to 1920s. Chinese hospitals were developed for aging Chinese workers, many of whom fell ill or destitute after the railway was completed and work was more difficult to obtain.<sup>56</sup> Chinese hospitals were funded by Chinese communities, in isolation from Western medical services. They were established in Victoria, New Westminster and Vancouver by local Chinese Benevolent Societies in the newly developed ‘Chinatowns’ that emerged in North America. These Benevolent societies were controlled primarily by wealthy Chinese merchants, though Chinese government officials were consulted in some cases. The Chinese Benevolent Associations were so concerned about the poverty and death they observed that they often sent leaflets to China to discourage workers from leaving China.<sup>57</sup> They created small charity hospitals as a solution for sick and indigent Chinese workers, but faced portrayals by the province’s journalists and sanitation officers as unsanitary ‘Pest houses.’ Chinese hospitals, such a Mount Saint Joseph’s hospital in Vancouver, were excluded from such characterization because they were described and applauded as beneficent charitable causes.<sup>58</sup>

The second largest group to emigrate from Asia were labourers from Japan. During the mid to late 1800s, only a few Japanese immigrants arrived in Canada. Tales of fortune and opportunity encouraged large waves of immigration to Canada. From 1896 to 1900, 12,788 Japanese arrived, though many immediately travelled south for work in the United States. Most of the workers came from the same few villages and prefectures in Japan. A large number arrived from the small fishing village of Mio-mura in Wakayama prefecture to work as

fishermen and boat builders in the enormously prosperous canning industry in Steveston and on the Skeena River in Northern British Columbia.<sup>59</sup> Japanese workers were often viewed more favourably by cannery owners because they were already skilled fishermen, could be paid lower wages than White workers, and did not have the burden of head taxes like Chinese labourers.<sup>60</sup>

Japanese immigration to Canada differed from that of other countries. The Japanese government had a prominent role in negotiating international immigration policies. Japan had won two significant military victories against China and Russia and was cognisant of its international status. The Japanese government did not easily allow its people to be subject to unfair treatment or racism by Western allies both in Japan and abroad. Canadian politicians were more cautious in their treatment of Japanese immigrants because Japan became closely allied with Britain during the early 1900s. Consequently, the Japanese consul had a much more active role in negotiating the policies affecting Japanese populations in Canada. For example, the Japanese government negotiated to reduce emigration during the early 1900s, when Canada and the United States considered policy to restrict Asian immigration. Other countries, like China and India, did little to respond to immigration policy during this time period.<sup>61</sup> In this study, I argue that the determination of the Japanese to build a modern medical hospital in British Columbia in 1900 was influenced by the consulate's desire to prove that Japan was different, particularly from China, and a country equal to Western nations like Britain and Canada.<sup>62</sup>

Comparing the history of hospital development for Chinese and Japanese in British Columbia populations brings forth important questions about how cultural and racial differences have influenced hospital and health care development over time. Moreover, understanding hospital development as a community strategy can illustrate how unique geographic, economic and political factors shaped the distinctive characteristics of Asian hospitals. For example, the

Japanese hospital in Steveston may not have existed had it not been for the local fishing industry that attracted large numbers of Japanese fishermen to the area. Understanding these local aspects demonstrates that hospital development in Canada was not only shaped by medical advancement, professionalization of health care occupations and by state-driven initiatives, but by local communities that established and maintained health care services during the turn of the twentieth century.<sup>63</sup>

## **Purpose**

The purpose of this study is to examine the history of the development of Asian hospitals within the social and cultural context in British Columbia from 1880 to 1920. Hospital development is explored in relation to local influences and community, as well as the role of those, particularly nurses, involved in establishment and operation of these early hospitals. Utilizing the lens of primarily non-medical stakeholders, shaped in many ways by the sources available, this study demonstrates that in some instances communities utilized and altered existing approaches to nursing and medicine to meet and negotiate their health needs.

## **Research Questions**

In this study, I attempt to answer several questions: How and why were Chinese and Japanese hospitals built in British Columbia at the turn of the twentieth century? How was the development of these hospitals influenced by the context of racism and anti-Orientalism? Were there differences between Chinese and Japanese hospital development? Why were missionaries often involved in the establishment of Asian health care services? How did the development of Chinese and Japanese hospitals compare to other hospitals at the time? How was the development of these hospitals shaped by local contexts (e.g. geography, health needs and economic, political and social factors) in British Columbia?

## **Significance**

The results of this study will add to nursing knowledge by providing a critical historical analysis of the development of Asian hospitals during the turn of the twentieth century. While nursing history scholars focus specifically on the practices and experiences of nurses,<sup>64</sup> there are many who also examine the medical, social and community contexts in which nurses' practice over time. For example, nursing history scholars have explored the influence of colonialism,<sup>65</sup> changes in technology,<sup>66</sup> and the history of hospital development.<sup>67</sup> Such studies have broadened the nursing profession's collective knowledge of how nursing work and contexts have been shaped by broader social changes, like the introduction of new scientific breakthroughs and modes of care, changing immigration patterns, or significant shifts in group power dynamics.

Hospitals have been and continue to be one of the most important contexts for nursing practice. The impetus for this study was because of a growing body of critical cultural scholarship focused on understanding how health care was shaped by a context often considered more overtly racist and prejudiced against non-White populations.<sup>68</sup> Though it was thought that this study might reveal more about the role of nurses in Asian health care development, it was actually found that during the late 1880s to early 1900s Asian communities themselves played a significant role in constructing Asian-targeted healthcare in British Columbia. This finding is important because it reveals that during this time period the development of some hospitals relied more on community activism, rather than the involvement of medical professionals or various levels of government. This insight itself has significance because it challenges the narrative of nurses as central to the development of health care and reveals that nurses today might take for granted the significance of community involvement in determining local health services.

## **Background and Historiography**

### **The Historiography of Asian Hospital Development in British Columbia**

Little historical scholarship exists related to the development of Asian hospitals during the turn of the twentieth century in Canada.<sup>69</sup> Of the studies available, most examine the history of Chinese hospital development.<sup>70</sup> Scholars discuss the transition of these hospitals from simple charity institutions to more modern medical facilities, integrating Western medicine with Eastern customs. For example, historian David Chuenyan Lai analysed the history of the Victoria's Chinese hospital that was established during the late 1880s.<sup>71</sup> In this study, Lai argues that the hospital was established as a form of self-segregation by Chinese residents because of a fear of Western medical procedures. Lai maintains that the Chinese hospital evolved over time and eventually utilized Western medicine, while providing care that was inclusive of Chinese customs, such as Chinese food and the use of Chinese languages. Similarly, Huguette Turcotte describes the establishment of Vancouver's Mount Saint Joseph Chinese hospital during the 1920s.<sup>72</sup> The hospital was begun as a charity mission for destitute and sick Chinese men by the Sisters of Immaculate Conception, but evolved into a large acute medical institution that combined Western medicine with Chinese traditions. Turcotte describes the hospital as an example of an important charitable work, provided by dedicated Catholic missionaries.

Other studies only briefly acknowledge the existence of Asian health care services during the turn of the twentieth century, such as an Oriental ward at Vancouver General Hospital that was established in 1907. Likely such wards were an attempt at segregation in response to increasing tensions between White and Asian workers.<sup>73</sup> Another Chinese hospital was briefly mentioned by a local historian that was established by the local Chinese Benevolent society in New Westminster during the 1920s.<sup>74</sup> Yet the development of Asian health care services within

the context of colonial British Columbia, as it relates to the rise of anti-Orientalism, broader international relations, and local community development has yet to be examined.

### **Asian Hospital Development Driven by a Context of Anti-Orientalism**

Although not much is known about Asian hospital development during the turn of the twentieth century in British Columbia, there exists a great deal of scholarship related to the context of racism against non-White groups that characterized this time period.<sup>75</sup> In this study, I argue that the establishment of hospitals for Asian populations was driven by the context of racism and anti-Asian rhetoric. As mentioned earlier, the majority of Asian immigrants were encouraged to enter Canada to provide a source of cheap labour for wealthy capitalists. As immigration increased, Asian workers increasingly faced racist views and policies. Scholars have analysed this period of ‘anti-Orientalism’ to highlight how stereotypes and misconceptions about cultural categories were popularized, often to maintain the dominance of White-European ideals and culture. However, there are different viewpoints as to the primary cause of racism during this time period.

Peter Ward, who published the seminal work, *White Canada Forever*, argues that anti-Orientalism and prejudiced national and local policies intensified not only by economic rivalries, but also because of popular racist attitudes and assumptions about what was then termed ‘Oriental’ groups.<sup>76</sup> Newspaper reporters and authors often portrayed Asian populations as diseased and uncivilized, incapable of assimilation and unwilling to adapt to Canadian life. In particular, Ward argues that early British Columbians wished for a homogeneous society where White British values and policies dominated.<sup>77</sup>

Ward discusses public perceptions of Chinese immigrants including hostile stereotypes and generalizations that led to disenfranchisement, and other forms of exclusion. Chinese

workers were characterized as an inferior race, accused of ‘taking White jobs’ and reducing the wages of White labourers.<sup>78</sup> During the late 1880s, several anti-Chinese labour groups formed when company owners hired Chinese workers as a way to break lengthy labour strikes.<sup>79</sup> These anti-Asian Labour groups passed out pamphlets encouraging citizens not employ or trade with Chinese labourers.<sup>80</sup> Furthermore, Chinese populations were accused of harbouring and spreading diseases like smallpox and leprosy, and were often ordered by city officials to clean or burn properties.<sup>81</sup>

Ward also analyzes the attitudes of White British Columbians of Japanese populations in Canada. He described how Japan, unlike China, was viewed as a country intent on expansion and international prestige. Japanese workers were viewed as fierce competitors, particularly in fishing and farming industries. Ward describes how Japanese fishermen were often prevented from obtaining fishing licences and how land ownership was threatened by anti-Asian labour groups. Tensions mounted until 1942 when all those of Japanese ancestry were forcibly relocated to internment camps as a result of the attack on Pearl Harbour during World War II. All lands, property and buildings owned by Japanese populations in Canada were seized and sold without compensation. The Japanese did not return to the West Coast until 1949. It was not until 1988 that redress movements resulted in compensation and apologies from the Canadian government.<sup>82</sup>

Although Ward’s work offers an in-depth account of anti-Orientalism in early British Columbian history, other historians suggest different reasons for the rise of racism. Patricia Roy, for example, studied the history of politics related to the anti-Asian sentiments in British Columbia from 1858-1914.<sup>83</sup> Unlike Ward, Roy argues that anti-Asian attitudes came about for important political reasons. She argues that the popularity of anti-Asian attitudes only surged

after economic conflicts mounted. Over time, however, race became the primary concern, as politicians rallied for White-European dominance. She argues that Asian populations became a convenient scapegoat for wealthy capitalists, who wished to keep wages low and profits high. Anti-Asian sentiment grew during political campaigns to garner favour with labourers who viewed Asian populations as a threat to White-dominated labour markets.<sup>84</sup>

The development of Asian hospitals in British Columbia was incited by the anti-Orientalist context of the time as a way for Asian populations to provide healthcare controlled by local communities. However, in this study I argue that not all Asian hospitals developed in the same way. That is, there were important differences between early Chinese and Japanese hospitals due to considerable political differences with respect to how Chinese and Japanese populations reacted to Western domination, racist attitudes and prejudicial policies during the turn of the twentieth century. Chinese hospitals in British Columbia were developed in isolation from Chinese government and were dependent on local Chinese Benevolent societies for funding and support.<sup>85</sup> These Chinese hospitals suffered much more scrutiny from journalists and the public because of the lack of political power abroad and locally within British Columbia. Chinese hospitals integrated Western medical approaches much later, likely due to the lifting of anti-foreign attitudes after the establishment of the Republic of China in 1912.

The Japanese hospital in Steveston, however, faced less public scrutiny, primarily because of the political reputation of the Japanese government abroad, but also because of the Japanese consul who argued for the need of a modern hospital. In this study, I claim that the Japanese consul understood that a modern hospital would be less scrutinized than a modest charitable hospital because of the context of hospital development in British Columbia during

this time period. Asian hospitals faced less public scrutiny when they conformed to the types of medical treatment and health care that were quickly becoming dominant in Canada.

### **Asian Hospitals in the Context of Canadian Hospital Development**

From the late 1800s to early 1900s, Asian hospital development was shaped by a significant period of growth within context of Canadian health care. During this time, hospitals were increasingly viewed as essential to Canadian life.<sup>86</sup> The hospital itself transformed from the former Victorian model of custodial care of the poor and needy, to modern scientific medical care for all.<sup>87</sup> Up until the 1910s, most health care was still provided in the home by physicians and private duty nurses.<sup>88</sup> Hospital development varied by province, depending on the presence of pioneer health workers. Yet by the 1920s, most cities and towns in Canada boasted a local hospital that provided scientific medical care and trained nursing staff.<sup>89</sup>

Provincial directories from 1863 to 1920 indicate that in British Columbia alone, over one hundred and fifty-five hospitals were established.<sup>90</sup> The majority of these hospitals were smaller, community and charity-based organizations, far from the large, comparatively standardized institutions we know today. There were marine, cottage and Catholic hospitals, as well as hospitals aimed at children, women, the elderly, the mentally ill and those with infectious disease. Several hospitals were built to provide care for particular racial groups, including Aboriginal, Chinese and Japanese populations. By the 1920s, general public hospitals became the primary mode of health care service delivery.<sup>91</sup> Yet, little is known about how this complex development of hospitals occurred; particularly within a context in which so much growth occurred prior to the implementation of Canada's publicly funded Medicare system.

Much of what has been studied about hospital development in British Columbia during the turn of the twentieth century is limited to the history of single institutions.<sup>92</sup> In Europe and

the United States, historians have examined the transition of general hospitals from institutes for the sick and destitute to modern scientific facilities.<sup>93</sup> They have analyzed hospital history primarily through the lens of institutional and medical advancement, examining improvements in treatment and development of health professions.

In nursing history scholarship, hospitals are often understood in relation to the education, training and professionalization of nursing.<sup>94</sup> Apprenticeship-style hospital-training became a fundamental tool of professional nursing, providing hospitals with a cost-effective and proficient labour force.<sup>95</sup> Similarly, scholars have studied the roles of various Catholic nursing orders in hospital development in the United States, Canada, the United Kingdom and Australia.<sup>96</sup> These studies often reveal the critical role that nursing sisters played in establishing early hospitals and skilled nursing prior to and after the rise of the Nightingale training model. Yet in recent studies, nursing historians have examined how nurses' work and health care have been altered as the context of health care has transformed. For example, nursing historian Geertje Boschma's study of community mental health nursing after 1950, demonstrates how the work of nurses and experiences of patients changed as mental health care was deinstitutionalized.<sup>97</sup> In this study, primary sources revealed the unique contribution of community leaders and workers in local hospital development, in contrast to many studies which solely utilize the perspectives of health workers, patients or hospital management.

Canadian scholars, David and Rosemary Gagan are among the few scholars to provide a glimpse of hospital history, prior to the establishment of Canada's publicly funded universal health system, during the first half of the twentieth century.<sup>98</sup> They argue that the development of larger general hospitals was influenced by the new germ theory, asepsis and the emergence of modern scientific medicine and professional nursing. These events resulted in an important shift

in the perception of the general hospital from a place of fear and passive treatment, to one of hope, where active medical treatment could be obtained.<sup>99</sup>

Gagan and Gagan argue that hospitals were altered during the 1890s to maximize profits and provide class-based care for whole populations.<sup>100</sup> For example, segregated wards and private rooms, which required extra fees, were reserved for the wealthy and middle class clients. However, poor and working classes were placed in large, open public wards. As hospitals and medical science attained further legitimacy, the financial burden of providing free treatment for lower classes became extremely costly and hospital boards began to argue that they could no longer afford their former charitable functions. By the 1920s, medical efficiency, service for those who could pay, and treatment of disease were favoured over socially-responsive treatment for all.<sup>101</sup>

Although class divisions became an important factor shaping the development of hospitals in British Columbia, this study reveals that culture and race have also influenced the history of hospital development. Chinese medical practitioners, for example, were practicing independently in the province as early as the 1860s.<sup>102</sup> Chinese hospitals were established during the 1880s in Victoria, New Westminster, Vancouver and Kamloops<sup>103</sup> and a Japanese fishermen's hospital was established in the small fishing village of Steveston, British Columbia in 1900.<sup>104</sup>

Though few scholars have examined the history of Asian hospital development, several have examined the development of services related to Aboriginal populations during this time period.<sup>105</sup> In general, scholars have found that these populations already had complex health practices long before colonization, but when Europeans arrived, health care services such as hospitals were organized, often established by government agencies or missionaries. These

services often promoted Aboriginal assimilation to Canadian life-ways and use of scientific medical techniques. However, Aboriginal health practices continued alongside Western practices. Aboriginal peoples themselves had a limited influence on the establishment of hospitals, and often only worked as support staff until the 1970s.<sup>106</sup>

In British Columbia, historian Mary-Ellen Kelm examined the history of Aboriginal health and health in British Columbia from 1900 to 1950.<sup>107</sup> Kelm argues that the processes of colonization shaped Aboriginal bodies and that the poor health of Aboriginal people was not created by pathogens alone, but by government policies. Although traditional medicine and health beliefs played an important role in Aboriginal communities, she argues that Western medicine served the colonial agenda by promoting the supremacy of Euro-Canadian health practices. Government instituted Indian health services were largely attempts to civilize and assimilate. Moreover, she argues that medical services were primarily organized as an attempt to prevent the spread of disease to White communities. Ultimately, however, the Canadian government did not take responsibility for improving health outcomes in Aboriginal communities. Aboriginal peoples did accept Western medicine techniques, but also held onto traditional healing. Moreover, Aboriginal views of illness and the body became fused to scientific ideas about pathology, rather than subordinate to it.

Similar experiences were faced by Aboriginal peoples in the Canadian plains. Historian Maureen Lux examined how disease was framed by race relations between European and Aboriginal peoples from 1880 to 1940.<sup>108</sup> Lux argues that the relationships between these groups, and the government policies that arose from them, came from the constructed view of the Aboriginal peoples as a ‘vanishing race’ doomed to extinction. The high rate of illness and disease in Aboriginal communities resulted in the sustained argument that good health was to be

achieved through Christian evangelism and assimilation. It was believed that if Aboriginal populations adopted Western ideology and health practices, their health would automatically improve. This belief allowed colonizers to blame Aboriginal peoples, rather than question the policies and practices that led to sustained poverty and poor health outcomes amongst Aboriginal populations.

A few scholars have highlighted the experiences of nurses working in Northern Aboriginal communities.<sup>109</sup> Dr. Myra Rutherford, for example, argued that not all nurses in the North viewed and practiced nursing in the same way, particularly in their approaches to Aboriginal populations.<sup>110</sup> In her study of Arctic Canadian Nurses from 1945-1970, Rutherford found that while some nurses engaged in work that could be characterized as ‘citizenship work,’ bent on changing traditional Aboriginal lives, others could be characterized as ‘optimistic adventurers,’ open to and curious about Aboriginal ways. Moreover, some nurses could be considered ‘cautious caregivers,’ carefully questioning the role of nursing in Aboriginal contexts.

Dr. Laurie Meijer Drees and Dr. Lesley McBain discuss similar findings to Rutherford in their study of outpost nursing in Aboriginal populations in Northern Saskatchewan from 1930-1954.<sup>111</sup> The attitudes of nurses towards Aboriginal community members in Saskatchewan varied, from ethnocentric to more sensitive and cautious modes of care. Outpost nurses in this study had an expanded role, which included a combination of duties associated with basic bedside nursing and public health nursing that would have been uncharacteristic of nursing roles in Southern locations. Moreover, Aboriginal peoples had little involvement as health care workers or in the development of hospitals. This finding has since been expanded upon further by Meijer Drees who more recently studied the history of Aboriginal people’s perspective of past experiences with Western medicine and Indian Health Services in Canada during the mid-

twentieth century.<sup>112</sup> Meijer Drees argues that Aboriginal medicine was never fully subsumed to Western medicine and Aboriginal peoples themselves continued to understand health and healing differently from scientific medical professionals. Prior to 1970, few Aboriginal people were trained in Western medicine, though support staff were often from local Aboriginal communities. Regardless of their training, Aboriginal health care workers provided an essential link between the Indian Health Service and the Aboriginal communities they served.<sup>113</sup>

Meijer Drees's findings demonstrate that the involvement of Aboriginal peoples in hospital development was quite different from that of Chinese and Japanese populations examined in this study. Many Indian hospitals were controlled by the federal government and as such most services were planned and developed by Indian services, with little involvement from Aboriginal peoples themselves.<sup>114</sup> Chinese and Japanese communities were more directly involved in hospital development and in many cases sought education in Western medical techniques earlier than their Aboriginal counterparts, who were largely excluded from educational opportunities beyond mission schools and the segregated residential school system.<sup>115</sup> Doctors and nurses of Asian-origin, for example, began to enter medical and nursing schools in Canada by the 1930s and 1940s.<sup>116</sup>

Overall, hospital development varied for Aboriginal, Chinese and Japanese populations during the turn of the twentieth century because it was shaped to some extent by the racist context of the time. Yet hospital development also varied for these groups depending on differences in culture, traditional medicine and responses to and experiences of Western domination. However, the development of these hospitals cannot be explained by racism alone. For example, the history of the Japanese hospital in Steveston was influenced by community activism shaped by various geographical, social, political and economic factors. Had Japanese

fishermen not been attracted to the area, been taken ill with typhoid fever and faced such strong opposition from White-labor groups, Japanese missionaries and the Japanese consul may have not have so strongly championed the need for a hospital in the area. Examination of the community's involvement in the development of the Japanese hospital reveals that the establishment of the hospital was influenced by complex and unique local factors.

### **Asian Hospital Development within the Context of Local Communities**

Although scholars have begun to examine the development of hospitals and health care services for some non-White groups in Canada during the turn of the twentieth century, few have attempted to explain why particular hospitals were organized differently, despite sharing a similar experiences of marginalization. In the United States, some scholars have discussed the importance of community and social contexts for framing the overall development of hospitals in particular regions or states.<sup>117</sup> For example, Vanessa Northington Gamble noted three different categories of Black hospitals built in the United States because of different community contexts.<sup>118</sup> Segregated Black hospitals were White-run hospitals that were primarily established in the Southern states to segregate and serve Black populations separately from White populations. Black-controlled institutions were developed as interracial hospitals requiring the support of both White and Black populations. These hospitals were established primarily to give Black physicians and nurses clinical opportunities unavailable in the segregated hospitals. The final type of Black hospital were those that were demographically-determined. These hospitals were not established by, or for, Black populations, but happened to have a primarily Black patient population because of the racial composition of nearby communities.

In this study, I argue that the Japanese hospital in Steveston was influenced by complex and unique local geographical, economic and political factors. For example, I describe how the

town of Steveston was located in one of the largest salmon fishing areas in the world, which encouraged the immigration of Japanese fishermen to the area. Outbreaks of typhoid fever amongst the Japanese fishermen created a demand for a hospital, but operations changed over time because of evolving needs and prosperity of the local Japanese community. At first, Japanese Methodist missionaries utilized a mission building as a make-shift hospital from 1896 to 1899, but as hospital debt mounted, the Japanese consulate and other community leaders suggested the need to build a modern hospital. It was through a meeting with the larger Japanese fishing community, that the consulate convinced the Japanese Fishermen's Benevolent Association to construct and begin operations for the new and modern Japanese Fisherman's hospital in 1900.<sup>119</sup>

The Japanese consulate argued the need for a modern hospital in response to increasing anti-Japanese sentiment amongst White labour groups. The consulate believed that building a modern hospital would demonstrate to the wider community that the Japanese people were worthy of Canadian citizenship and the hospital would symbolize their progress and intention to stay in Canada. The threat of anti-Japanese measures, such as limiting Japanese access to fishing licenses, intensified and motivated the fishermen to act, demanding fairer fish prices as a means to provide health services for Japanese workers. The hospital itself was utilized as leverage for Japanese fishing leaders during fishing price negotiations. For example, the Benevolent Association board asked for lump sum payments to maintain hospital operations, in addition to increases in individual fishing prices from cannery owners. The hospital was also used in arguments against the removal of Japanese fishermen from the fishing industry in Canada. Though the hospital board faced substantial debts and the threat of closure, the Japanese hospital itself symbolized much more than a medical facility. To the Japanese fishermen, the hospital

symbolized resistance to the economic and political dominance of White-European culture. In addition to being a source of nursing and medical care, the hospital represented the Japanese community's desire and ability to be accepted as naturalized Canadian citizens.

## Notes on Methodology

### Social Historiography

A social history approach was utilized to examine the establishment and development of Chinese and Japanese hospitals in British Columbia, in their social and cultural context from 1880 to 1920. Combining ethos from both history and social sciences, social history is the study of society over time, often focusing on trends as they relate to social structures.<sup>120</sup> Social history enables historians to understand the link between individual experiences over time and broader social processes.<sup>121</sup> Social history evolved as a reaction to studies of dominant and powerful historical figures, to a more inclusive framework that incorporates the study of everyday people and events.<sup>122</sup> In nursing history scholarship, social history is often defined as the study of history via reinterpretation of past events, with particular focus on the experiences of ordinary people.<sup>123</sup> Researchers utilizing a social history framework generally view their materials through a particular category of analysis, often focusing on understanding the role of class, gender and race in shaping experience.

In this study, the development of Chinese and Japanese hospitals is examined utilizing race and culture as the most important category of analysis. My primary objective was to understand the role of cultural relations in Canada and abroad in relation to the development of Asian hospitals at the turn of the twentieth century. For instance, I discuss how Asian hospital development was linked to the broader anti-Oriental context of the time, encouraging Asian groups to build health services that would be owned and operated by Asian communities.

In addition to race, class was also an important category of analysis. The development of Chinese and Japanese hospitals is compared and linked to broader social, political and economic trends. In particular, I examine how relations with Western nations during the mid-1800s influenced differences in the way that Chinese and Japanese hospitals developed in Canada. International relations abroad affected how these communities responded to prejudice within Canada and can help explain why Chinese communities faced more criticism as a threat to public health, than Japanese populations.

Religion became an important factor to examine as missionaries were involved in several aspects of health service development for Asian populations, including establishment of the Japanese mission hospital. Methodist doctrine encouraged involvement in charitable works, including education and health care. However, the establishment of the Japanese hospital was unique in that it was established and controlled by Japanese missionaries themselves, rather than White Christians. This allowed the Japanese community more control over the hospital, though Christianity in general provided Asian populations in Canada with opportunities that would have been otherwise difficult given the racist context of the time. Christian conversion provided Asian individuals with a new identity, conveying a willingness to assimilate, bridging the perceived racial gap between Asian and White identities.

Finally, I discuss the history of the Japanese hospital in Steveston, as it related to complex and unique local factors, particularly the economic and political fortunes of the Japanese fishermen. Small hospitals, like the Japanese hospital, were reliant on local communities for building and operations costs, as they received very little financial assistance from any level of government during the late 1880s to early 1900s. Despite much support from the Japanese consulate and Japanese fishermen, the Japanese Fishermen's Benevolent

Association found hospital debts difficult to manage. To contend with these difficulties the Association eventually utilized the hospital as leverage in fish price negotiations.

## Theoretical Considerations

In addition to the social history approach utilized in this study, a critical theoretical perspective of culture was utilized to analyse the influence of culture and race on the development of Chinese and Japanese hospitals in British Columbia at the turn of the twentieth century.<sup>124</sup> This perspective of culture, influenced by critical social theory, a philosophical paradigm utilized in nursing research and scholarship, encourages nurses to develop knowledge which further examines power relationships, oppression, social justice, and inequities in nursing and health care.<sup>125</sup> Though ‘culture’ is a complex, controversial concept with many meanings and interpretations, it is often conflated with concepts such as race and ethnicity. This latter view of culture has often been defined in nursing scholarship as the essentialist view of culture.<sup>126</sup> From this viewpoint, culture is viewed as a group of people sharing a particular essence or set of beliefs and values. Culture is different from the concept of race and ethnicity in that race tends to refer specifically to shared physical characteristics (e.g. skin color, facial features), while ethnicity tends to refer to country or region of origin (e.g. Canadian, Northerner).

The essentialist view of culture has been critiqued within nursing scholarship for several reasons.<sup>127</sup> Many argue that proponents of the essentialist view take for granted the dynamic and socially constructed nature of cultural categories. Those who support the essentialist view often describe today’s cultural categories as ‘fact’ rather than human-made. They may not acknowledge that dominant groups and their belief systems are often accepted as the norm, while other groups are constructed as different or diverse. In this study, a critical view of culture is taken to examine cultural groups as constructed, dynamic, and related to particular power

structures in society. Furthermore, culture is analyzed as an important influence on a person's social capital and value such that they might obtain a better social status in some contexts, while in other contexts they may be discriminated against and marginalized. Cultural categories within this framework encourages researchers to discuss how particular individuals are constructed as outsiders or insiders, and acknowledge the complexity within and between groups. The primary aim is to understand how particular categories are constructed and for what purposes in various contexts.

### **Notes on Sources**

Unlike many studies of hospital history during the turn of the twentieth century, this study is distinctive in that most sources were derived from the local Chinese and Japanese communities who built hospitals, rather than from the staff or administrators of medical institutions. Understanding hospital development from this particular lens reveals that the fate of Chinese and Japanese hospitals were closely tied to the political abilities and economic fortunes of members of some of the first Asian communities in British Columbia.

To undertake this study, I drew upon various archival sources across the Pacific Northwest. Several secondary sources related to the development of Chinese hospitals were utilized in Chapter 1.<sup>128</sup> For example, there were sources that included translated records pertaining to the Chinese hospital in Victoria<sup>129</sup> and a Chinese medical textbook utilized in Seattle, Washington, during the time period under study.<sup>130</sup> Along with secondary sources, primary sources were utilized, including records from the University of Victoria Archives Chinese-Canadian Collection<sup>131</sup> and newspaper articles, primarily from the University of Victoria Digital Collections online version of The British Colonist.<sup>132</sup> All records related to the Chinese hospital in New Westminster originated from the New Westminster City Archives,

including two Chinese patient record books that were translated for this study.<sup>133</sup> The record books contain the names, ages, cities of origin and time in hospital, including date of death for over three hundred patients who stayed at the hospital. Sources utilized for the discussion of the Mount Saint Joseph's hospital were primarily secondary, because most primary sources were not readily available within the parameters of this study.<sup>134</sup> All sources related to the development of Chinese hospitals in British Columbia were analyzed for information about how and why various hospitals and health services were developed, and for what purposes.

To examine the role of the Methodist Missionaries in the establishment of the first Japanese Mission hospital, I utilized primary sources almost exclusively from the United Church British Columbia Conference at the Bob Stewart Archives.<sup>135</sup> Records included annual reports from Methodist Missionary Society, articles from the *Methodist Recorder* and various biographical files and church records. Important secondary sources for Chapter 2 included a translated book related to the history of the Japanese United Church Congregations of Canada,<sup>136</sup> as well as Stanley Osterhout's 1929 study of 'Oriental's in Canada' related to the work of members of the Canadian Methodist Church amongst Asian groups during the early part of the twentieth century.<sup>137</sup> Sources related to the Methodist missionaries were analyzed for any information related to the Japanese home missions and how Methodist missionaries were involved in the development of the Japanese hospital. Records were also examined for information about various Chinese, Japanese and Aboriginal missions, and missionary perspectives of these groups.

For the final two chapters of this study, I utilized translated portions of two books that were originally published by Japanese historians in Japanese (kanji) language during the 1920s and 1930s.<sup>138</sup> The first book, by Jinshiro Nakayama, was examined for sections that addressed

the history of the Japanese fishing community in relation to the development of the hospital in Steveston, British Columbia (Encyclopedia of the Japanese in Canada). The second book, by Teiji Kobayashi, was analyzed for the history of the Japanese Fishermen's Benevolent Association, and its involvement in the fishing industry and hospital operations. These two books can be found at the University of British Columbia Special Collections and Nikkei National museum archives. The books were part of an eleven part Japanese-language series on the history of Japanese populations in Canada.

Through funding obtained at the University of British Columbia, School of Nursing, I was able to have a portion of Nakayama's book translated by trained professionals at Colombo translation in Vancouver, British Columbia (Glenn Patterson, Yasumi Yasuoka and Alice Ungarini). Kobayashi's work was translated through a member of the Steveston Community Centre, who was assisted by Richmond City Councillor Bill McNulty.

## **Chapters in Brief**

There are four chapters in this study, organized both chronologically and thematically. Although the primary focus of this study is of the history of the Japanese hospital in Steveston, I begin the study with an analysis of the development of Chinese hospitals in British Columbia to provide an important comparison to the Japanese hospital. The inclusion of a discussion of the history of Chinese hospitals was important for this study because they were the first Asian hospitals developed in the Pacific Northwest during the turn of the twentieth century and several historians have already analyzed their development.<sup>139</sup>

In Chapter 1, I focus on the establishment of Chinese hospitals in Victoria, Vancouver and New Westminster as small charity buildings offering modest accommodation, familiar food and Chinese medicine. I argue that these particular hospitals faced more scrutiny than the

Japanese hospital, from both the public and medical authorities because Chinese populations had less social status and political leverage than Japanese populations. Though local benevolent associations became responsible for protecting Chinese interests in Canada, their role in upholding the reputation of Chinese hospitals was viewed as secondary to promoting inter-relationships within Canadian Chinese communities. The preference for Chinese rather than Western medicine, for example, meant that Chinese hospitals were more vulnerable to scrutiny from Western medical practitioners. Japanese populations more eagerly sought to ‘Westernize’ the hospital in Steveston, to avoid this scrutiny and quell arguments that the Japanese did little to contribute to the local community. This chapter not only reveals that culture shaped the development of hospitals during the turn of the twentieth century, but that these hospitals developed differently because of important cultural and political differences within Canada and abroad.

In Chapter 2, I examine the role of the Methodist missionaries in the establishment of the first Japanese mission hospital in Steveston, British Columbia from 1893 to 1899. I discuss how Methodist religious ideology required church members to participate in “good works” such as health care, to fulfill spiritual obligations. I describe how the majority of Methodist mission work actually took place within Canada, often amongst groups viewed as in need of Christian intervention, including several non-White groups. Over time, missionary work amongst these groups promoted assimilation as a primary goal. From a paternalistic and ethnocentric viewpoint, many White missionaries argued that if non-White populations were exposed to Christian teachings and British culture it would help integrate them into a “modern” and “civilized” society.

Although mission work amongst non-White groups in Canada was founded on these same principles, health care development amongst Aboriginal, Chinese and Japanese populations was organized differently. Aboriginal hospitals were established by White-missionaries, often with little involvement from Aboriginal populations themselves in day-to-day operations. The Methodist church did not establish hospitals for Chinese communities, yet Methodist missionaries played an important role in the education of Chinese students in medical sciences. The Japanese mission hospital in Steveston was a unique enterprise because it originated from Japanese Christian Methodist missionaries themselves. Despite efforts to staff the mission hospital entirely with Japanese workers, White medical missionaries were utilized to assist with hospital operations. It was not long, however, until plans were made by Japanese community leaders to encourage the Japanese fishermen to establish and operate a new modern hospital in Steveston. Overall, I argue that Christianity offered non-White groups opportunities to participate in aspects of Canadian life, like healthcare, that otherwise would have been difficult during this time period. Christian conversion could bridge the perceived racial gap between Asian and White identities

In Chapter 3, I argue that during the turn of the twentieth century, the history of small community-based hospitals were dependent on complex local conditions that shaped hospital size, funding as well as type of patient and provider. The Japanese fishermen's hospital was built in Steveston because it was in one of the largest salmon fishing areas in the world. The fishing industry attracted a large number of Japanese workers, who were already proficient fishermen and boat builders. However, they were accustomed to safely drinking river water in Japan, and as a result became ill more often than any other group in Steveston at the time. The transition from charity mission hospital to modern hospital (1897-1900) was influenced by changes in Japan that

took place during the Meiji Period (1868-1912). During this time, Japan's government responded to imperial threats from Western nations with a modernization campaign that promoted Western-style industrialization and militarization. Japan's subsequent military victories against China and Russia solidified Japanese international reputation as an imperial power, equal to Western nations.

Influenced by these international victories, Japanese leaders in Steveston promoted the building of a modern hospital to protect the Japanese community from rejectionist arguments. The Japanese consulate gave a compelling speech to convince the Japanese Fishermen's Benevolent Association to replace the make-shift Methodist mission with a modern hospital in 1900. The history of the Japanese hospital demonstrates that hospital development in Canada was not only shaped by the expansion of medical science, or professionalization of health providers, small hospitals could also be community strategies, shaped by unique geographical, cultural, political and economic conditions.

In Chapter 4, I examine two translated histories which provide information about the establishment and operation of the modern hospital from 1900 to 1919. Unlike many of today's prevailing studies of hospital history at this time, the use of these secondary texts has provided the unique opportunity to analyse the development of the Japanese hospital from the perspective of Japanese community leaders. Analysis of these texts demonstrates that the Japanese hospital's history became inextricably linked to the fate and fortunes of the Japanese fishermen. The hospital itself was utilized as a source of leverage in fishing price negotiations. Over time the hospital became an important political tool in the Japanese community's fight for racial and economic equality. This chapters demonstrates that hospitals have functioned as more than the

workshop of medical science or training ground for health providers, but could also play an important role in Canada's race relations.

## **Summary**

The purpose of this study was to understand the development of Chinese and Japanese hospitals in British Columbia during the late 1800s to early 1900s. Understanding the history of Asian hospitals is relevant for nursing because the hospital has been the primary practice context of nurses in Canada for well-over one hundred years. Examining the development of hospitals over time reveals important insights about how health care has been shaped by changing contexts. In this study, I analyze important questions about how culture and a context of Anti-Orientalism influenced the development of hospitals. I argue that for many Chinese and Japanese groups, it was important to have access to and control over hospitals that offered care compatible with cultural customs and language. I also argue that these groups developed health care differently, depending on cultural and political differences in Canada and abroad.

Another reason this study is important for nursing is that many scholars and practitioners are increasingly interested in understanding how culture and race shapes health care services and delivery.<sup>140</sup> There have been concerns that interventions have too often been focused on changes that could be made at the level of the individual nurse-client relationship, rather than broader institutional, organizational or population levels.<sup>141</sup> For example, nurses have often been encouraged to learn more about specific cultural customs and incorporate them in practice. Yet, in many fast-paced, acute-care focused practice settings, it was often simply impossible to make such changes, and underlying tensions and inequities often remain unaddressed.<sup>142</sup> Moreover, many nurses and nursing educators have found it difficult to address cultural needs or instances of racism, because of the uncomfortable nature of the topic.<sup>143</sup>

The findings in this study might provide an opportunity for nurses to not only discuss how culture and race has shaped health care over time in Canada, but how race relations impacted broader social, economic and political factors which influence nursing work and workplaces. For example, in this study, I utilize critical historical analysis to reveal that hospitals can be more than modern scientific institutions or the training ground for health professionals. The hospital itself can be an important political tool in the fight for racial and economic equality. In the case of the Japanese hospital, because the hospital board was comprised of Japanese leaders, they could deviate from dominant models of medical/nursing care to provide Japanese workers with opportunities, such as work as untrained nurses or support staff, which would have been difficult to obtain during the racist context of the time. This insight is important because it reveals that during this time period, community involvement and control was an important consideration for how hospitals could be utilized to confront racism and marginalization and for providing more socially just and equitable health care services.

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<sup>1</sup> Gagan and Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950*.

<sup>2</sup> Ibid.

<sup>3</sup> Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work* (Baltimore, MD: The John Hopkins University Press, 2010).; Patricia D'Antonio, Julie A. Fairman and Jean C. Whelan, eds. *Routledge Handbook on the Global History of Nursing* (London: Routledge Taylor & Francis Group, 2013).; Kathryn McPherson, ed., *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto, ON: Oxford University Press, 1996).; Sioban Nelson, *Say Little, do Much: Nursing, Nuns, and Hospitals in the Nineteenth Century* (Philadelphia, PA: University of Pennsylvania Press, 2001).; Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge: Cambridge University Press, 1987).

<sup>4</sup> Vancouver Public Library, "British Columbia City Directories 1860-1955," *Vancouver Public Library*, accessed November 17, 2014, <http://www.vpl.ca/bccd/index.php>

<sup>5</sup> Ibid.

<sup>6</sup> Teiji Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi* [35 Year History of the Steveston Fishermen's Benevolent Society], Vol. 4 (Tokyo, Japan: Fuji Shuppan, 1935).

<sup>7</sup> Ibid.

<sup>8</sup> David Chuenyan Lai, "From Self-Segregation to Integration: The Vicissitudes of Victoria's Chinese Hospital," *B.C. Studies* 80 (Winter, 1988/89): 52-68.

<sup>9</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*.

<sup>10</sup> Ibid.

<sup>11</sup> Jean Barman, *The West Beyond the West: A History of British Columbia*, 3rd ed. (Toronto, ON: The University of Toronto Press, 2007), 134.

<sup>12</sup> See, for example, Patricia E. Roy, *White Man's Province: British Columbia Politicians and Chinese and Japanese Immigrants 1858-1914* (Vancouver, BC: The University of British Columbia Press, 1989), part 1.

<sup>13</sup> Lai, "The Chinese Consolidated Benevolent Association in Victoria: Its Origins and Functions," *B.C. Studies* 15 (1972): 53-67.; Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*.

<sup>14</sup> See Michael R. Auslin, *Negotiating with Imperialism: The Unequal Treaties and the Culture of Japanese Diplomacy* (Cambridge, MA: Harvard University Press, 2004), China and Japan's negotiations with Western powers are compared extensively in this work.

<sup>15</sup> Ibid., 19-22.

<sup>16</sup> Ibid.

<sup>17</sup> Lai, "From Self-Segregation to Integration," *B.C. Studies* 80 (Winter, 1988/89): 52-68.; These hospitals would have been similar to what has been discussed by Guenter B. Risse, *Plague, Fear and Politics in San Francisco's Chinatown* (Baltimore, MD: The John Hopkins University Press, 2012), 51.

<sup>18</sup> Lai, "From Self-Segregation to Integration," 52-68.

<sup>19</sup> Ibid.

<sup>20</sup> The Chinese consulate was not established in Canada until 1908.

<sup>21</sup> Roy, *White Man's Province*, 92.

<sup>22</sup> Peter Ward, *White Canada Forever: Popular Attitudes and Public Policy Toward Orientals in British Columbia*, 3rd ed. (Montreal, QC: McGill-Queen's University Press, 2002), 75.

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- <sup>23</sup> Ibid., 138.
- <sup>24</sup> Ibid., 61.
- <sup>25</sup> Ibid., 133.
- <sup>26</sup> Kathryn McPherson, ed., *Bedside Matters.*; Susan M. Reverby, *Ordered to Care*.
- <sup>27</sup> Karen Flynn, "Beyond the Glass Wall: Black Canadian Nurses, 1940-1970," *Nursing History Review* 17 (2009): 129-152.
- <sup>28</sup> Susan Smith, *Japanese American Midwives: Culture, Community, and Health Politics, 1880-1950* (Champaign, IL: University of Illinois Press, 2005).
- <sup>29</sup> Roy, *White Man's Province*, 9-10.
- <sup>30</sup> Ibid., 230
- <sup>31</sup> Vanessa Northington Gamble, "The Negros Hospital Renaissance: The Black Hospital Movement, 1920-1945," in *The American General Hospital: Communities and Social Contexts*, eds. Diana E. Long and Janet Golden (Ithaca, New York: Cornell University Press, 1989).
- <sup>32</sup> Neil Semple, *The Lord's Dominion: The History of Canadian Methodism* (Montreal, QC: McGill-Queen's University Press, 1996).
- <sup>33</sup> Ibid., ch. 11.
- <sup>34</sup> Ibid., 169.
- <sup>35</sup> Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950* (Vancouver, BC: University of British Columbia Press, 1998).
- <sup>36</sup> Chantal Gauthier, *Women without Frontiers: A History of the Missionary Sisters of the Immaculate Conception, 1902-2007* (Outremont, QC: Les Editions Carte Blanche, 2008).; Jiwu Wang, *His Dominion" and the "Yellow Peril": Protestant Missions to Chinese Immigrants 1859-1967* (Waterloo, ON: Wilfrid Laurier University Press, 2006).
- <sup>37</sup> Stanley S. Osterhout, *Orientals in Canada* (Toronto, ON: Ryerson Press, 1929), 133-170.
- <sup>38</sup> See Roland M. Kawano, ed., *A History of the Japanese Congregations of the United Church of Canada, 1892-1959: A Pathway through the People of Grace*, trans. Ed Yoshida, Seiichi Ariga and Shinji Kawano (Scarborough, ON: The Japanese Canadian Christian Churches Historical Project, 1998).
- <sup>39</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*.
- <sup>40</sup> Barman, *The West Beyond the West*, 16.
- <sup>41</sup> Ibid., 15-19.
- <sup>42</sup> Ibid., 26-52.
- <sup>43</sup> Ibid., 56-64.
- <sup>44</sup> Ibid., 65-74.
- <sup>45</sup> Ibid., 76-161.
- <sup>46</sup> Paul Yee, *Saltwater City: An Illustrated History of the Chinese in Vancouver* (Vancouver, BC: Douglas & McIntyre, 2006), 10.
- <sup>47</sup> Ibid., 10.
- <sup>48</sup> Ibid., 11.
- <sup>49</sup> Ibid., 11.
- <sup>50</sup> Ibid., 32.
- <sup>51</sup> Ibid., 11.
- <sup>52</sup> Ibid., 5.
- <sup>53</sup> Peter Li, *The Chinese in Canada*, 2nd ed. (Don Mills, ON: Oxford University Press Canada, 1998), see ch. 2.
- <sup>54</sup> Ward, *White Canada Forever*, 37.

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- <sup>55</sup> Li, *The Chinese in Canada*, 34.
- <sup>56</sup> Megan Davies, *Into the House of Old: A History of Residential Care in British Columbia* (Montreal, QC: McGill - Queen's University Press, 2003), 69.
- <sup>57</sup> David Chuenyan Lai, "Chinese Attempts to Discourage Emigration: Some Findings from the Chinese Archives in Victoria," *B.C. Studies* 18 (1973): 37, <http://prophet.library.ubc.ca/ojs/index.php/bcstudies/article/viewFile/776/818>.
- <sup>58</sup> Andrea Geiger, *Subverting Exclusion: Transpacific Encounters with Race, Caste, and Borders, 1885-1928* (New Haven, CT: Yale University Press, 2011), 8-9.
- <sup>59</sup> Masako Fukawa and Stanley Fukawa, *Spirit of the Nikkei Fleet: BC's Japanese Canadian Fisherman* (Surrey, BC: Harbour, 2009), 14-15.
- <sup>60</sup> Roy, *White Man's Province*, 81-83.
- <sup>61</sup> Ibid., see ch. 5.
- <sup>62</sup> See Jinshiro Nakayama, *Kanada Doho Hatten Taiken Zen* [Encyclopedia of the Japanese in Canada], Vol. 7-8 (Tokyo, Japan: Fuji Shuppan, 1921), 642-643.
- <sup>63</sup> Histories of single public hospitals often tend to foreground the work of medical staff, and therefore tend to examine the development of medical science and related professions.
- <sup>64</sup> See Diana J. Mansell, *Forging the Future: A History of Nursing in Canada* (Ann Arbor, MI: Thomas Press, 2004) and McPherson, *Bedside Matters*.
- <sup>65</sup> Margaret Jones, "Heroines of Lonely Outposts or Tools of the Empire? British Nurses in Britain's Model Colony: Ceylon, 1878-1948," *Nursing Inquiry* 11, no. 3 (2004): 148-160.; Sue Forsyth, "Telling Stories: Nurses, Politics and Aboriginal Australians, C. 1900-1980s," *Contemporary Nursing* 24, no. 1 (2007): 33-44.
- <sup>66</sup> Julie Fairman and Joan E. Lynaugh, *Critical Care Nursing: A History* (Philadelphia, PA: University of Pennsylvania Press, 1998).; Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill, NC: University of North Carolina Press, 2000).; Cynthia Toman, "Blood Work: Canadian Nursing and Blood Transfusion, 1942-1990," *Nursing History Review* 9 (2001): 51-78.
- <sup>67</sup> Patricia D'Antonio, *Founding Friends: Families, Staff, and Patients at the Friends Asylum in Early Nineteenth-Century Philadelphia* (Bethlehem, PA: Lehigh University Press, 2006).; Geertje Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam: Amsterdam University Press, 2003).; Joan E. Lynaugh, "From Respectable Domesticity to Medical Efficiency: The Changing Kansas City Hospital, 1875-1920," in *The American General Hospital: Communities and Social Contexts*, eds. Diana E. Long and Janet Golden (Ithaca, New York: Cornell University Press, 1989), 21-39.
- <sup>68</sup> Helen E. R. Vandenberg, "Culture Theorizing Past and Present: Trends and Challenges," *Nursing Philosophy* 11, no. 4 (2010): 238-249. doi: 10.1111/j.1466-769X.2010.00453.x
- <sup>69</sup> Lai, *From Self-Segregation to Integration*, 52-68. From the handful of studies on Asian hospitals in Canada (referenced fully in the subsequent notes) it appears the Chinese hospitals in Canada likely have been similar to what has been discussed by Risso, *Plague, Fear and Politics*, 51, in San Francisco's Chinatown, which were established around the same time.
- <sup>70</sup> Lai, *From Self-Segregation to Integration*, 52-68.; Huguette Turcotte, "Hospitals for Chinese in Canada: Montreal (1918) and Vancouver (1921)," *CCHA Historical Studies* 70 (2004): 131-142, [http://www.umanitoba.ca/colleges/st\\_pauls/ccha/Back%20Issues/CCHA2004/Turcotte.pdf](http://www.umanitoba.ca/colleges/st_pauls/ccha/Back%20Issues/CCHA2004/Turcotte.pdf)
- <sup>71</sup> Lai, *From Self-Segregation to Integration*, 52-68.
- <sup>72</sup> Turcotte, *Hospitals for Chinese in Canada: Montreal (1918) and Vancouver (1921)*, 131-142.

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<sup>73</sup> David Gagan and Rosemary Gagan, "“Evil Reports” for “Ignorant Minds”? Patient Experience and Public Confidence in the Emerging Modern Hospital: Vancouver General Hospital, 1912." *Canadian Bulletin of Medical History* 18, no. 2 (2001): 349-367.

<sup>74</sup> Jaimie McEvoy, *The Life and Destruction of Saint Mary’s Hospital* (New Westminster, BC: Saint Mary’s Health Foundation, 2008), 78-79.

<sup>75</sup> See Hugh Johnston, *The Voyage of the Komagata Maru: The Sikh Challenge to Canada’s Colour Bar* (Vancouver, BC: The University of British Columbia Press, 1989).; Roy, *White Man’s Province*; Roy, *The Oriental Question: Consolidating a White Man’s Province, 1914-41* (Vancouver, BC: The University of British Columbia Press, 2003).; Timothy J. Stanley, "“Chinamen, Wherever we Go”: Chinese Nationalism and Guangdong Merchants in British Columbia, 1871-1911," *The Canadian Historical Review* 77, no. 4 (1996): 475-503. doi: 10.3138/CHR-077-04-01; Stanley, ""By the Side of Other Canadians": The Locally Born and the Invention of Chinese Canadians," *B.C. Studies* 156/157, no. 156/157 (Winter/Spring, 2007): 109-139.; Ward, *White Canada Forever*.

<sup>76</sup> Ward, *White Canada Forever*.

<sup>77</sup> Ibid.

<sup>78</sup> Ibid., 43.

<sup>79</sup> Ibid., 38.

<sup>80</sup> Ibid., 45.

<sup>81</sup> Ibid., 52.

<sup>82</sup> Ibid., see part 3.

<sup>83</sup> Roy, *White Man’s Province*.

<sup>84</sup> Ibid.

<sup>85</sup> Lai, *From Self-Segregation to Integration*, 52-68

<sup>86</sup> David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (McGill - Queen's University Press: Montreal, QC, 2002).

<sup>87</sup> Ibid., see ch. 1.

<sup>88</sup> See Catherine Bates, Dianne Dodd and Nicole Rousseau, eds., *On all Frontiers: Four Centuries of Canadian Nursing* (Ottawa, ON: University of Ottawa Press, 2005), 45.

<sup>89</sup> See Gagan and Gagan, *For Patients of Moderate Means*.

<sup>90</sup> Provincial directories were business listings similar to what is found in today’s telephone directories. These directories have been digitized by the Vancouver Public Library and can be found online, <http://www.vpl.ca/bccd/index.php>

<sup>91</sup> Gagan and Gagan, *For Patients of Moderate Means*, 66.

<sup>92</sup> See Peter Walton, *The VGH Story: A History of Vancouver General Hospital* (Vancouver, BC: Vancouver General Hospital, 1988).; Sally Carswell, *The Story of Lions Gate Hospital: The Realisation of a Pioneer Settlement’s Dream 1908-1980* (West Vancouver, BC: K. Carswell and S. Carswell, 1980).; Herbert H. Murphy, *Royal Jubilee Hospital, Victoria BC: 1858-1958* (Victoria, BC: Hebden Print, 1958).

<sup>93</sup> Gagan and Gagan, *For Patients of Moderate Means*; Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (New York: Basic Books, 1987); Guenter B. Risse, ed. *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999).

<sup>94</sup> Patricia D’Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work* (Baltimore, MD: The John Hopkins University Press, 2010).; McPherson, *Bedside* 40

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Matters; Carol Helmstadter, "Reforming Hospital Nursing: The Experiences of Maria Machin," *Nursing Inquiry* 13, no. 4 (2006): 249-258. Reverby, *Ordered to Care*.

<sup>95</sup> Ibid.

<sup>96</sup> Sioban Nelson, *Say Little, Do Much.*; Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions* (Piscataway, NJ: Rutgers University Press, 2011).

<sup>97</sup> Geertje Boschma, "Community Mental Health Post-1950: Reconsidering Nurses' and Consumers' Identities," in *Routledge Handbook on the Global History of Nursing*, eds. P. D'Antonio, J. Fairman and J. Whelan (London: Routledge Taylor & Francis Group, 2013), 237-258.

<sup>98</sup> Gagan and Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950*.

<sup>99</sup> Ibid., 39-40.

<sup>100</sup> Ibid., 39.

<sup>101</sup> Ibid., 97.

<sup>102</sup> Frederick P. Howard and George Barnett, *British Columbian and Victoria Guide and Directory* (Victoria, BC: Howard, Frederick P.; Barnett, George, 1863),

[http://www.vpl.ca/bccd/index.php/browse/title/1863/British\\_Columbia\\_Guide\\_and\\_Directory](http://www.vpl.ca/bccd/index.php/browse/title/1863/British_Columbia_Guide_and_Directory)

<sup>103</sup> Victoria Daily Colonist, "Kamloops." *Victoria Daily Colonist*, March 31, 1896,

<http://archive.org/stream/dailycolonist18960331uvic/18960331#page/n0/mode/1up>

; David Chuenyan Lai, *Chinatowns: Towns within Cities in Canada*. (Vancouver, BC: The University of British Columbia Press, 1988).

<sup>104</sup> Vancouver Public Library, "British Columbia City Directories," *Vancouver Public Library*, <http://www.vpl.ca/bccd/index.php> (accessed February/11, 2014).

<sup>105</sup> See Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950*; Maureen K. Lux, *Medicine that Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940* (Toronto, ON: University of Toronto Press, 2001); Laurie Meijer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton, AB: The University of Alberta Press, 2013).

<sup>106</sup> Meijer Drees, *Healing Histories*, 166.

<sup>107</sup> Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950*.

<sup>108</sup> Lux, *Medicine that Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940*.

<sup>109</sup> Jayne Elliot, Mervyn Stuart and Cynthia Toman, eds., *Place and Practice in Canadian Nursing History* (University of British Columbia Press: Vancouver, BC: 2008); Myra Rutherford, ed., *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada* (McGill-Queens University Press: Montreal & Kingston: 2010).

<sup>110</sup> Myra Rutherford, "Cleansers, Caregivers, and Optimistic Adventurers: A Proposed Typology of Arctic Canadian Nurses, 1945-1970." In *Place and Practice in Canadian Nursing History*, eds. J. Elliot, M. Stuart and C. Toman, (University of British Columbia Press: Vancouver, BC: 2008), 53-90.

<sup>111</sup> Laurie Meijer Drees and Lesley McBain, "Nursing and Native Peoples in Northern Saskatchewan: 1930s-1950s," *Canadian Bulletin of Medical History* 18 (2001): 43-65.

<sup>112</sup> Meijer Drees, *Healing Histories*.

<sup>113</sup> Ibid., see ch. 6.

<sup>114</sup> Ibid., 11-40.

<sup>115</sup> Ibid., see ch. 6.

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- <sup>116</sup> McPherson, *Bedside Matters*, 210.
- <sup>117</sup> Diana E. Long and Janet Golden, eds., *The American General Hospital: Communities and Social Contexts* (Ithaca, New York: Cornell University Press, 1989).
- <sup>118</sup> Northington Gamble, "The Negros Hospital Renaissance," 82.
- <sup>119</sup> Hence, there were actually two Japanese hospitals, the first I term the Japanese Mission Hospital (1896-1899) and the latter the Japanese Fishermen's Hospital (1900-1941).
- <sup>120</sup> Werner Conze and Charles A. Wright, "Social History," *Journal of Social History* 1, no. 1 (1967): 7.
- <sup>121</sup> C. Tilly, "The Old New Social History and the New Old Social History," *Review (Fernand Braudel Center)* 7, no. 3 (1984): 363.
- <sup>122</sup> Peter Stearns, "Social and Political History," *Journal of Social History* 16, no. 3 (1983): 3-5. doi:10.1353/jsh/16.3.3
- <sup>123</sup> Joy Buck, "Using Frameworks in Historical Research." in *Capturing Nursing History: A Guide to Historical Methods in Research*, eds. S. B. Lewenson and E. K. Herrmann (New York: Springer, 2008), 45-62.
- <sup>124</sup> Diana L. Gustafson, "Transcultural Nursing Theory from a Critical Perspective," *Advances in Nursing Science* 28, no. 1 (2005): 2-16.; Vandenberg, "Culture Theorizing Past and Present: Trends and Challenges," *Nursing Philosophy* 11, no. 4 (2010): 238-249. doi: 10.1111/j.1466-769X.2010.00453.x
- <sup>125</sup> Annette J. Browne, "The Potential Contributions of Critical Theory to Nursing Science." *Canadian Journal of Nursing Research* 32 (2000): 35-55.
- <sup>126</sup> Patricia Gray and Debera J. Thomas, "Critical Reflections on Culture in Nursing," *Journal of Cultural Diversity* 13, no. 2 (2006): 76-82.
- <sup>127</sup> Joan Anderson and others, "'Rewriting' Cultural Safety within the Postcolonial and Postnational Feminist Project: Towards New Epistemologies of Healing," *Advances in Nursing Science* 26, no. 3 (2003): 196-214.; Melanie Dreher and Neil MacNaughton, "Cultural Competence in Nursing: Foundation or Fallacy?" *Nursing Outlook* 50, no. 5 (2002): 181-186. doi: 10.1067/mno.2002.125800; Vandenberg, "Culture Theorizing Past and Present: Trends and Challenges," 238-249.
- <sup>128</sup> Lai, "From Self-Segregation to Integration: The Vicissitudes of Victoria's Chinese Hospital," 52-68.; Risse, *Plague, Fear and Politics in San Francisco's Chinatown*.
- <sup>129</sup> Lai, "From Self-Segregation to Integration: The Vicissitudes of Victoria's Chinese Hospital," 52-68.; Lai, "The Chinese Consolidated Benevolent Association in Victoria: Its Origins and Functions," 53-67.
- <sup>130</sup> Paul D. Buell and Christopher Muench, "Chinese Medical Recipes from Frontier Seattle," *The Annals of the Chinese Historical Society of the Pacific Northwest* (1984): 100-143.
- <sup>131</sup> University of Victoria Archives, Chinese-Canadian Collection, University of Victoria Libraries, Victoria, British Columbia,  
<http://www.uvic.ca/library/featured/collections/asian/Chinese-Canadian.php>
- <sup>132</sup> University of Victoria Digital Collections, (Online edition, The British Colonist 1858-1920, University of Victoria Libraries, Victoria, BC, <http://www.britishcolonist.ca/index.html>.)
- <sup>133</sup> New Westminster Archives, New Westminster Chinese Benevolent Society, *Chinese Hospital Records*, 1904-1967, IH 980.30.
- <sup>134</sup> Many records related to the early years of this hospital are located at the Missionary Sister of Immaculate Conception Archives in Laval, Quebec. These records are written in French and would have to be translated for an English-speaking audience.

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<sup>135</sup> The archives are currently located at the Vancouver School of Theology at the University of British Columbia, however, a recent sale of the building means that a new location for these sources will be inevitable.

<sup>136</sup> Kawano, *A History of the Japanese Congregations of the United Church of Canada, 1892-1959: A Pathway through the People of Grace.*

<sup>137</sup> Osterhout, *Orientals in Canada.*

<sup>138</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*; Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi.*

<sup>139</sup> See Lai, "From Self-Segregation to Integration: The Vicissitudes of Victoria's Chinese Hospital."; Risso, *Plague, Fear and Politics in San Francisco's Chinatown.*; Turcotte, *Hospitals for Chinese in Canada.*

<sup>140</sup> Madeleine Leininger, *Transcultural Nursing: Concepts, Theories, Practices* (New York: John Wiley, 1978).; Annette J. Browne, "Clinical Encounters between Nurses and First Nations Women in a Western Canadian Hospital," *Social Science & Medicine* 64 (2007): 2165-2176.; Vandenberg, "Culture Theorizing Past and Present: Trends and Challenges," 238-249. doi: 10.1111/j.1466-769X.2010.00453.x.

<sup>141</sup> De Jesus, Maria, "The Importance of Social Context in Understanding and Promoting Low-Income Immigrant Women's Health". *Journal of Health Care for the Poor and Underserved* 20 (2009): 90-97. doi: 10.1353/hpu.0.0126.; Truong, Mandy, Yin Paradies, and Naomi Priest.

"Interventions to Improve Cultural Competency in Healthcare: A Systematic Review of Reviews." *BMC Health Services Research* 14 (2014): 99-116. doi:10.1186/1472-6963-14-99.

<sup>142</sup> Ibid.

<sup>143</sup> Jacqui Allen, Lucinda Brown, Carmel Duff, Pat Nesbitt and Anne Hepner, "Development and Evaluation of a Teaching and Learning Approach in Cross-cultural care and Antidiscrimination in University Nursing Students," *Nurse Education Today* 33 (2013): 1592–1598. doi:10.1016/j.nedt.2012.12.006.; Stuart Baird, Carolyn Hardy, Martyn Harling, Logan Parumal and Melanie Narayanasamy, "Diversity and Ethnicity in Nurse Education: The Perspective of Nurse Lecturers," *Nurse Education Today* 32 (2012): 203-207. doi:10.1016/j.nedt.2011.02.012.

# **CHAPTER 1: THE HISTORY OF CHINESE HOSPITALS IN**

## **BRITISH COLUMBIA: A CASE FOR COMPARISON**

Chinese hospitals were the first Asian hospitals to be established in the Pacific Northwest during the turn of the twentieth century. In this chapter, I discuss the development of Chinese hospitals in British Columbia from the mid-1800s to mid-1900s. I argue that Chinese hospitals integrated Western medical ideas later than Japanese populations, because of important differences in the way that China and Japan responded to Western imperialism during the mid-1800s. Chinese medical doctors were accessible in the province as early as the 1860s, but began to face public scrutiny during the 1880s as Western medical practitioners promoted their practices as the most trustworthy and legitimate form of medicine. Several Chinese hospitals were established in British Columbia during the 1880s and were founded by local Chinese Benevolent Associations. These early hospitals mimicked charity hospitals found in China at the time and offered food, shelter and Chinese medicine.<sup>1</sup> Newspaper journalists and sanitary inspectors often characterized early Chinese hospitals unsanitary public health hazards.

Although local benevolent societies attempted to improve the status of Chinese hospitals by seeking help from local government, they were provided little assistance. Over time, Chinese hospitals integrated Western medicine and faced less public criticism. In Victoria, the Chinese hospital began to receive financial support from the city beginning in the 1930s. In Vancouver, a Chinese hospital was established in 1921 by Catholic missionaries called the Missionary Sisters of Immaculate Conception. This hospital utilized Western scientific medicine and Chinese physicians trained in Western medicine. Early Chinese hospitals integrated Western medical practices later than the Japanese hospital in Steveston and as a result faced more criticism and

public scrutiny. This chapter demonstrates that culture and race were important factors shaping hospital development during the turn of the twentieth century in Canada, and that there were important cultural and political differences that influenced differences between Chinese and Japanese hospitals.

### **Chinese Immigration and Isolation in British Columbia**

During the 1850s, Chinese immigrants arrived in North America not only to take advantage of the promise of fortune, but also to escape political upheaval and economic hardship in China.<sup>2</sup> Between 1838 and 1900, several Western countries, beginning with Britain and France, initiated wars with China to force unequal trading treaties and seize territorial rights. Western countries viewed China as a weak nation, to which they could sell finished products and extract raw materials and cheap labour for further production. Foreign domination disrupted the autonomy and economic prosperity in China and accelerated domestic conflict.<sup>3</sup>

In addition to foreign influence, population growth added to the mounting internal tensions in China. From 1750 to 1850, the population doubled from about 200 million to 410 million.<sup>4</sup> At the same time, farming productivity decreased due to several floods and droughts. These events intensified the friction between wealthy landlords and poverty stricken peasant-tenants. Desperation eventually led the peasants to revolt against landlords during the Taiping rebellion in Southern China from 1850 to 1864. The rebellion was crushed by the government with the assistance of foreign nations who wanted to maintain the status quo. The imperialist threat from European powers was met with ‘self-strengthening’ and ‘anti-foreign’ campaigns in China during the late Qing dynasty (1861-1895).<sup>5</sup>

The most well-known anti-foreign uprising was called the Boxer Rebellion (1898-1900), in which a group of northern peasants who called themselves the Yihequan (meaning “Righteous

and Harmonious Fists") violently killed Chinese Christians and Western missionaries.<sup>6</sup> At first the Boxers opposed the Qing dynasty, but when they received support from the imperial palace, they primarily focused their efforts on removing all Western influence from China. These anti-foreign sentiments and international reputation as a weak nation, placed Chinese workers immigrating to Canada in a less influential position abroad, as compared to those from Japan, who were viewed favourably because Japan was seen as an emerging world power.<sup>7</sup>

Though the Chinese government was informed by concerned Chinese Benevolent Associations about the problems of immigration to Canada during the early 1900s, responses were often evasive or indecisive.<sup>8</sup> This lack of international engagement on the part of the Chinese government meant that Chinese immigrants faced more regulation and public scrutiny than other groups, like the Japanese, who had a consulate in Canada earlier and were able to avoid the head taxes faced by Chinese immigrants due to actions by the Japanese government.<sup>9</sup>

The popularity of anti-foreign policies and attitudes in China may explain why, unlike the modern Japanese Fishermen's hospital, Chinese communities in Canada took longer to integrate Western ideas with local health care services. Another reason being that Chinese medicine was widely available and preferred by Chinese workers who settled in many different communities in British Columbia.<sup>10</sup>

### **Chinese Medicine in British Columbia**

An examination of British Columbian directories (1860-1920) reveals that as early as the 1860s, Chinese doctors were practicing Chinese medicine in British Columbia.<sup>11</sup> These directories, which are equivalent to today's business directories, listed various business and residential addresses in British Columbia's growing cities and villages. These directories also listed the names and occupations of persons by address. As Asian populations grew, many

directories created separate lists for Chinese and/or Japanese Businesses. According to a 1863 provincial directory, Dr. Lee-y-Shang and Wing Yan Lung practiced on Cormorant Street in the newly developed Chinatown of Victoria.<sup>12</sup> Chinese doctors and druggists could soon be found in almost every area of British Columbia that had a sizable working Chinese population. By 1884, there were 12 Chinese doctors in Victoria, six in New Westminster, six in Nanaimo, and four in Wellington and several others were located in mining and railway camps scattered across the province.<sup>13</sup>

The most prominent, successful and enduring Chinese medical practices were found within the confines of the newly established ‘Chinatowns’ in Canada. As argued by historian Kay Anderson, Chinatowns emerged in North America as a White European construction of ‘Chineseness’ which reinforced the ‘Otherness’ of the Chinese in Canada.<sup>14</sup> Chinese populations were very clearly defined as ‘different’ and physically separated from their White European counterparts. Chinatowns also served as a haven and self-contained community for the Chinese populations which built them. Chinese labourers often returned to Chinatown after seasonal or contract labour ended.<sup>15</sup>

Chinatowns were ‘towns within cities’ that changed over time and shaped the development of Chinese life in Canada.<sup>16</sup> David Lai argues that Chinatowns underwent several stages of development including a budding (1858-1870s), blooming (1880s-1910s) and withering phase (1920s-1970s).<sup>17</sup> These phases, shaped by important immigration and labour patterns influenced the history of Chinese hospitals in Canada. During the budding phase from 1858 to the late 1870s, Chinatown would have consisted mainly of wooden shacks and cabins populated by a large male labouring class, with a few wealthy merchants. During this time period,

provincial and city directories indicate the presence of the services of a few Chinese doctors, and several Chinese drug stores. Chinese hospitals were not built until the early 1880s.<sup>18</sup>

Though Chinese medicine is often discussed as a unified category of health care, quite distinct from Western, scientific medicine, there are several separate streams of practice that evolved over time. Chinese medicine was well-over 1500 years old by the time it arrived in the Pacific Northwest and was influenced by various medical practices around the world. Chinese medicine consisted of several different practices including surgery, massage, bone setting, breathing exercises, herbal remedies, moxibustion<sup>19</sup> and acupuncture. One of the greatest theoretical developments was made during the Han Dynasty (206 BC – 220 CE) when a unified medical philosophy would detract from the idea that disease was caused by spirits. This new philosophy meant that illness was now viewed as a system of integrated causes and effects, rather than a single bodily dysfunction. Treatment was directed to restore balance to a system which had been disturbed by the environment or other factors.<sup>20</sup>

Herbal medicine was the primary type of Chinese medicine practiced in British Columbia, but over the years, there were also several practitioners offering surgery and bone-setting.<sup>21</sup> In China, herbal shops were separate businesses from Chinese medical practices, but in the Pacific Northwest, Chinese herbal stores and medical practices were often combined. Most Chinese doctors had practices in the corner of the local Chinese general store and a few had entire shops devoted exclusively to the practice.<sup>22</sup> Those with the most affluent shops had elaborate equipment and fixtures from China or Hong Kong. The central feature was a large cabinet with 70 or more dispensary drawers. Each drawer had three or four compartments labelled for a variety of medications. The medicine was carefully prepared in a kitchen and preparation area. Herbs and other substances, which were ordered from China, would have

arrived in large crates and would be cleaned and then chopped, ground, flattened or crushed. A large foot-powered grinder was used for hard substances like shells and a table-top chopper was used for softer substances like roots. A variety of sieves were used for sifting materials into fine powders. Once prepared, the raw medicine was placed in the drawers and other shop containers.<sup>23</sup>

When a customer arrived at the shop, he or she would be assessed and a particular remedy would be prescribed. Practitioners relied upon complex Chinese medical texts which contained instructions for assessment, herbal recipes, acupuncture and other treatments. Although at least two of these texts are available in archives in British Columbia, they have not yet been translated.<sup>24</sup> In the United States, one pioneer Chinese medical text from Seattle, Washington has been translated by historians Paul Buell and Christopher Muench.<sup>25</sup> Analysis of this book revealed a set of ‘base’ or basic recipes, which were targeted at a particular organ and/or symptom, but would have been altered by the herbalist to meet the individual needs of the patient. The book titled “Yao-fang” or “Medicinal recipes” contained 166 recipes, many of which consisted of 8 to 20 ingredients, with the exception of a few recipes which would contain up to a hundred or more ingredients. Many recipes were organized by specific disease or symptom, rather than more abstract disease categories common in professional Chinese medicine. The chief categories of recipes included those for sexually transmitted diseases, traumatic injury, respiratory illness, gastrointestinal complaints, tonics, anti-smoking or anti-opium recipes as well as eye, ear and throat recipes. However, several recipes were designed as general tonics to prolong and improve life.<sup>26</sup> After a recipe had been chosen, the Chinese herbalist would carefully measure and weigh several ingredients for preparation as a drink, tea or pill. Most formulas were packaged in paper to be taken home for consumption, but many were

prepared in the herbalist's shop, making these shops important spaces for socializing in Chinatown.<sup>27</sup>

The most prominent time for Chinese medical and druggist practices in British Columbia was during the 'Blooming Period' (1880-1910) when Chinese populations grew rapidly in Victoria and Vancouver.<sup>28</sup> Many of the old wooden shacks were replaced by brick structures, as Chinese merchants grew more prosperous. By 1887, Victoria had at least two Chinese doctors Chan Dan Tong and Shu Sun, four druggists and two drug stores on Cormorant and Government Streets.<sup>29</sup> In Vancouver, Chinese druggists did not become a familiar site until the early 1900s when there were at least two to three shops consistently in the city. The most enduring Chinese drug store was the Dan Yock Tong drug store on Cormorant Street, in Victoria's Chinatown.<sup>30</sup> The practice was established as early as 1884, and appears in city directories until 1914. Chinese doctors and druggists in Canada served both Chinese and non-Chinese customers in the 1870s as services were regularly advertised in local newspapers as well as city and provincial directories.<sup>31</sup>

In California, Chinese medical practitioners were argued by Paul Buell to have primarily served Chinese communities, but over time increasingly served a large number of White residents.<sup>32</sup> Buell argues that the popularity of Chinese medicine among White clientele was thought to have been due partly to the lack of or frustration with Western medicine in some communities, and because of a decrease in the Chinese population in certain cities. Many Chinese workers returned to China at the end of the gold and silver mining booms. The population was further reduced by immigration restrictions during the 1900s that made it difficult for Chinese workers to bring their wives and families into the United States. During this time, Chinese doctors returned to China and others passed on their business and possessions to

other Chinese physicians or to Chinese community associations. Buell argues however, that this may not have been the case in British Columbia as Chinese populations stayed more stable, only decreasing during the ‘withering’ of Chinatowns within British Columbia during the 1930s and 1940s.<sup>33</sup>

Chinese medical practitioners were mostly perceived by the non-Chinese public as ‘quacks’ though a minority believed they had some merit. A journalist of the provincial newspaper, *The Victoria Daily Colonist* shared public opinions about Chinese doctors in a 1905 article.<sup>34</sup> According to the journalist, there were known to be at least two types of doctors. The first class were almost exclusively accessed by lower class Chinese and was described as using amulets and magic to drive away the evil spirits of disease. The second class of Chinese doctors was viewed as more respectable, but mysterious. The journalists described this class as utilizing medical texts known to be centuries old and was passed down from generation to generation. Patients were assessed by the pulse in the fingers, wrist and arm to determine conditions of the heart and other organs. Though the author mentions nothing about treatment or effectiveness of these practices, it was noted that neither class of physician were recognized as legitimate by law. Chinese medical practices were certainly characterized by the public as separate from, and not as ‘modern’ as Western health services.<sup>35</sup>

In Canada, Chinese doctors also faced scrutiny from local medical societies.<sup>36</sup> In 1872, one year after British Columbia joined confederation, the provincial government denied anyone of Chinese ancestry the right to vote. This not only made it difficult for Chinese individuals to obtain positions of power in government, but also prevented them from joining respected professions, such as law or pharmacy. However, there is no indication that any person was denied from practicing medicine because of the loss of franchise. The Medical Act, which was

passed in 1886, required those wishing to be a registered physician to provide proof of their education, pay a ten dollar registration fee and pass a one hundred dollar medical exam.<sup>37</sup> It is probable then that it was medical schools in Canada which were primarily responsible for excluding Asian students from training in Western medicine, though little research exists on this topic in Canada.

It was during the 1880s to 1920s that Western medical practitioners were intent on professionalizing and promoting their practice as the most trustworthy and legitimate form of medicine.<sup>38</sup> It was not uncommon then for these physicians to discredit other forms of medicine including homeopathy and non-scientific healers.<sup>39</sup> Chinese doctors were also discredited in later years. For example, in 1896 reports in the provincial newspaper reveal that two Chinese medical doctors were prosecuted by the Vancouver Medical Society for practising in British Columbia.<sup>40</sup>

Despite these cases, Chinese doctors were occasionally consulted in matters which were considered foreign to Western medical doctors in the province. For example, during the early 1880s, a prominent physician in Victoria, John Sebastian Helmcken referred a case of suspected leprosy to local Chinese doctors for diagnosis, stating he believed they would be more familiar with the disease.<sup>41</sup> In later years, cases of leprosy were quarantined directly by public health officials. Though Helmcken's statement might point to their being more collaboration between Chinese and Western physicians before medical societies and public health officials discouraged cooperation, it is also likely that he passed on cases of leprosy to Chinese physicians due to the stigma of leprosy during this time period.

### **Early Chinese Hospitals in British Columbia**

During the early 1880s, several Chinese Hospitals were established by local benevolent association in cities along the Pacific Northwest including Victoria, Vancouver, and New

Westminster in British Columbia. These early hospitals mimicked charity hospitals found in China at the time.<sup>42</sup> They were small, modest operations that provided basic shelter, food and Chinese, rather than Western medicine. Early Chinese hospitals were characterized by newspaper journalists and sanitary inspectors as horrifying ‘Pest Houses’ that were far below Western standards.<sup>43</sup> There was great demand for these hospitals after the completion of the Canadian Pacific Railway (CPR) left Chinese workers who arrived in Canada during the 1860s and 70s aged and impoverished.<sup>44</sup> The majority of the patients who accessed Chinese hospitals were single men, who had no spouses or family to take responsibility for care of the elderly or sick. Many of these men were also poor and wished to be buried according to Chinese customs. Though some of these men utilized General Public hospitals, like Vancouver General, Chinese hospitals would also provide care that reflected Chinese beliefs, values and languages.

Local Chinese Benevolent Associations provided the first Chinese hospitals in the province because they took on the role of protecting Chinese interests in Canada during this time period.<sup>45</sup> These Benevolent Associations were led by wealthy Chinese merchant classes and as such were sometimes criticized for placing the interests of merchants above those of individual Chinese workers. This may have been one factor influencing the poor the status of Chinese hospitals, which were primarily used by the indigent and working classes.<sup>46</sup>

### **The Chinese Hospital in Victoria**

The Chinese Consolidated Benevolent Association (CCBA) in Victoria was the first to be formally registered with the provincial government, in August of 1884. The primary objective of the Association was to promote inter-relationships within Canadian Chinese communities, to combat social ills such as crime, prostitution and violence, as well as provide both social and legal defences against racial prejudice and discrimination. The members of the CCBA viewed

their role in the development of health care as secondary, but they were chiefly responsible for the development of the first Chinese-targeted hospitals in British Columbia. The 1884 constitution and by-laws of the CCBA in Victoria reveal that an agreement had been made to build a hospital and provide relief and social welfare for poor and sick Chinese citizens. To fund the Association and its activities, a law was passed requiring all Chinese citizens over fourteen years of age to pay a small fee to the Association. Chinese workers were asked to donate at least two dollars to the Association or pay ten dollars when they wanted to return to China. Over \$30,000 was raised, with the vast majority being spent on the new CCBA building.<sup>47</sup>

In 1884, the CCBA of Victoria built the first hospital, called the ‘Taipingfang’ or peaceful room.<sup>48</sup> It was a small wooden structure, located just behind the Benevolent Association in the heart of Victoria’s Chinatown. The Taipinfang functioned as both a shelter to protect the sick and dying and as a morgue for the dead. Those who utilized the building had to pay for their own food and medicine; however, if two guarantors could confirm a patient was genuinely poor, the CCBA would grant money for medical expenses and supply two meals at twenty cents per day.<sup>49</sup> Thus, the functions of the first Chinese hospitals were more as charitable shelters and spaces to convalesce, rather than places to receive treatment for acute illness. Similar hospitals could be found in many of the Chinatowns along the West coast of North America, including San Francisco.<sup>50</sup>

Medical historian Guenter Risse describes the Chinese hospital in San Francisco as part of the local Chinese funeral home.<sup>51</sup> Risse argues that Chinese hospitals in North America mirrored those found in China during the late Qing dynasty. In large Chinese cities, private benevolent societies sponsored shelters as well as public dispensaries offering medical services, including health advice and herbal medicines. A variety of foreign missionary dispensaries and

hospitals were also present in China during this period. Reverend William Speer worked as medical missionary in China and returned to open a free dispensary in San Francisco's Chinatown. He later proposed a hospital be built within the area, but was refused due to resistance from California authorities who believed that a hospital would only further spread disease. Thus Chinese patients, particularly those with infectious disease, were often relegated to a 'Pest house' located outside the city.<sup>52</sup>

After ten years of operation, the Chinese Taipingfang in Victoria began to face public criticism, particularly from the provincial newspaper. During the early 1890s, reporters from the British Colonist characterized the hospital as a "Death House" with poor, unclean conditions.<sup>53</sup> As historian Nayan Shah argues, Chinese populations in both the United States and Canada were often subject to characterizations such as the "Yellow Peril" and the source of disease and unsanitary conditions in various cities.<sup>54</sup> These characterizations were popularized by public health officials and politicians and contributed to the construction of Chinatown and Chinese populations as a civic health problem to be managed by the city and board of health. Chinese communities in British Columbia faced these same characterizations and calls for regulation. An outbreak of smallpox in the summer of 1892, led public demand for appointment of the first medical health officer in British Columbia.<sup>55</sup> Journalists and White labourers fomented concerns about sanitary conditions in Chinatown, hoping to spur anti-Asian labour agitation.<sup>56</sup>

On December 24, 1892 a news reporter characterized the Taipingfang in Victoria as little more than a filthy shack, inadequate for care of the sick. The article titled "Shocking State of Things" describes the Taipingfang as the old 'Chinese hospital' on Fisgard Street.<sup>57</sup> The journalist reported that the hospital was inspected by medical health officer Dr. George Duncan, who found an unattended dying man on the floor of the small wooden shack. The dying man was

described as naked, on a wooden bench with a piece of dirty canvas covering his body. He was given some rice, and the building was described as rat-infested, filthy, lacking comfort and care.<sup>58</sup>

Despite the poor conditions, reporters described the attempts of the medical health officer to work with the CCBA to prevent the hospital from being removed by the health inspector. Medical officer Duncan requested the premises be cleaned and the patient attended to by a nurse. The CCBA attempted to have the hospital cleaned, but when the reporter returned, he deemed these attempts inadequate. The health officer was contacted by the reporter to return to the hospital once again.<sup>59</sup>

The newspaper reporter accompanied the medical health officer on his next visit and reported that upon arrival at the hospital, Medical officer Duncan was surprised that conditions had not changed significantly. The patient that they had observed earlier was still in poor condition and thought to be suffering from cold and starvation. The sanitary inspector, Mr. J.P. Burgess was quoted as stating, "...it is simply disgusting...something must be done to get him out of here, or else have him made comfortable. True enough he is a Chinaman, but you would not leave a dog to die like that."<sup>60</sup> The statement clearly demonstrates the ethnocentric and racist viewpoint of the sanitary inspector. These observations may also point to the serious lack of resources for sick and indigent Chinese workers in British Columbia at the time.

Still, the article reveals that the reporter and health officer were determined to blame the poor hospital conditions on the local Chinese Benevolent society in Victoria. They attempted to visit the Chinese Benevolent president, but he was said to be unreachable. In the meantime, the medical officer arranged to have food sent to the patient and promised to ensure care was given. The reporter argued that the man was the sole responsibility of the Chinese Benevolent

Association, and he should not be a burden to the public or any other charitable institution. This was a common argument made by members of the anti-Asian labour movement of the day.<sup>61</sup>

Victoria's news reporters not only blamed the Chinese Benevolent Society for the poor conditions of the hospital, they accused them of mismanaging the funds they had received from fellow Chinese workers. One reporter remarked, "It is claimed that the Chinese Benevolent Society levies an assessment upon each Chinaman arriving in the country, the money so obtained being supposed to be expended in the proper equipment and maintenance of an institution for the sick and needy."<sup>62</sup> From the reporter's point of view, the funds were best spent on ensuring that Chinese citizens were not a burden to tax-paying citizens. Historian David Lai argues that 35,822 Chinese citizens left for China between 1891 and 1910, the income would have been approximately \$3600 a year.<sup>63</sup> But because the role of the hospital was secondary for the Association, the majority of the money that was initially collected was spent on the newly built brick Association building and Chinese temple (Joss House) in Victoria.<sup>64</sup>

By 1892, it was clear that the Chinese Benevolent society did not have the financial backing to bring the hospital to the standards deemed acceptable by the city health officer.<sup>65</sup> The Chinese Benevolent members approached the city health officer to attempt to gain financial support from the city to help maintain the hospital. No answer was given, but it was claimed that the matter would later be brought before city council. Five prominent Chinese merchants promised to have the hospital cleaned, heated and supervised. They also promised that the hospital would be kept open at all times for inspection by the sanitary inspector and city health officer.<sup>66</sup>

In the meantime, a report titled 'Another Dead Chinaman' appeared about the unclean state of the Chinese hospital.<sup>67</sup> On New Year's Eve 1892, new arrival Chin Toi Hou was

reported to have died in the hospital. On the same page, an article titled “Unclean Chinatown” demonstrated that reporters of the Daily Colonist continued to portray Chinatown as a filthy and unwholesome place.<sup>68</sup> They claimed that the Chinese faced upwards of one hundred health-related offences in the month of December and were regularly ordered, often through court involvement, to clean property.

On February 16, 1893, it was reported that a sick Chinese man, suspected of having leprosy, died in the Chinese hospital.<sup>69</sup> Another man was reported to have committed suicide to avoid being taken to the leprosy colony on Darcy Island. Called the ‘Island of Death’ by newspaper reporters,<sup>70</sup> the colony or ‘lazaretto’ was used to quarantine and exile 49 men with leprosy between 1891 and 1924.<sup>71</sup> According to local historian Chris Yorath, the large majority of these men were Chinese and faced this treatment due to the stigma associated with the disease, medical ignorance and racism.<sup>72</sup> The leprosy colony on Darcy Island was viewed by medical officer Duncan as necessary to protect the public, though little was known about how the disease was spread at the time.<sup>73</sup> The city council of Victoria hoped costs of the colony would be taken over by the Dominion government, as had been done in New Brunswick, but requests for financial assistance were ignored. The colony, which was established in 1891, consisted of several small shacks and was completely isolated except for a small supply boat bringing food, opium and coffins every three months. The history of the leper colony on Darcy Island demonstrates that Chinese men, particularly those with communicable illness, were viewed from a paternalistic and racist standpoint.

On February 19, 1893, another article titled “The Chinese Dead House” was written discussing the deaths of four more Chinese men at the Chinese hospital. This time the bodies were found by sanitary inspector Mr. Chipcase.<sup>74</sup> Two Chinese men had died in the morning,

another died the previous day, and another horribly emaciated body was left without an explanation. The corpses were described as ragged and the bodies suffered from starvation before death. When the sanitary inspector and medical health officer were contacted about the poor conditions of the hospital, both said that promises had been made by prominent men in Chinatown to improve conditions. A caretaker had been hired two weeks previously. Medical officer Duncan was concerned that respiratory disease and typhoid were prevalent among Chinese workers, and could be spread throughout the city. As a result, he consulted with the city coroner to appeal the city council to establish a morgue.<sup>75</sup>

In later months, more bodies were found in the hospital and a particularly bad outbreak of smallpox led medical health officer Duncan to vaccinate all in Chinatown.<sup>76</sup> Editorial commentators praised his efforts and the task of ensuring sanitation in Chinatown was promoted.<sup>77</sup> Despite the focus on Chinatown as the centre of public health risk, race was carefully argued by an anonymous reader not to be a cause of the health concerns in Chinatown. Rather it was argued that any part of the city would be dealt with similarly, if sanitation was compromised. The writer stated, “We do not say this because Chinatown is the point of danger and because it is Chinamen who are to be dealt with. If any other part of the city were in the same condition and its inhabitants were addicted to the same practices, we would advocate their being treated in precisely the same way. No citizen, whether he is a European or an Asiatic, should be allowed to do what endangers the public health.”<sup>78</sup>

Medical health officer Duncan himself regularly argued that in combination with the large number of laundries in Chinatown and the fact that there was no proper sewage system in Chinatown, it was not surprising that the sanitation of the area had been compromised.<sup>79</sup> He asked city council to consider lengthening the main sewer line to Chinatown as soon as possible.

He also strongly advocated for an infectious disease hospital, with appropriate disinfecting station as well as better reporting of infectious diseases by physicians. The medical health officer's opinions were not unexpected given that several years earlier, six of Victoria's doctors argued that disease in the city was most likely related to improper drainage and poor enforcement of sanitary laws.<sup>80</sup>

On March 23, 1893, the medical health officer reported that a number of prominent Chinese merchants promised to improve the Chinese hospital. Despite his attempts to work with the Chinese community, many members of city council attempted to have the hospital closed. It was decided that city council did not have power to do this, and they instructed the health officer to strictly enforce the health by-law in regards to the hospital.<sup>81</sup>

Many Chinese residents in Victoria were displeased by the treatment they received from the medical health officer and as a result many avoided the smallpox vaccination. By May of 1894, medical health officer Duncan had been taken to court for unlawful confinement of Chinese passengers from Hong Kong. Lawyers for Wong Hoy Woon argued that unlike their European counterparts, they were unfairly confined and disinfected by the health officer. Duncan lost the case and was required to pay damages.<sup>82</sup>

The prejudice experienced by Chinese doctors and the Chinese hospital in Victoria echoed the paradox of racial discrimination described by historian Patricia Roy in her study of attitudes towards Asian immigrants during the turn of the twentieth century.<sup>83</sup> Though Chinese health services were subject to regulation and inspection for not living up to 'Western' standards, Chinese hospitals were at the same time prevented from achieving such standards because of the economic and social prejudice placed on them by White British Columbians.

Yet the CCBA continued to operate the hospital, despite these attempts to regulate operations. In 1899, a new brick hospital to replace the former wooden hospital at 555 Herald Street. This hospital was later renovated in 1922, with funding from local Chinese interest groups. Unfortunately the CCBA struggled to meet yearly costs and repeatedly asked City council if they would exempt the hospital from city taxes. These requests were ignored and the hospital was sold in a Tax sale in 1929. Ironically, the city helped the CCBA continue operations by charging a modest rent, yet the hospital almost closed again in 1938 when costs became overwhelming. This time the city helped to subsidize operations and officially had the hospital registered as a convalescence home, under the jurisdiction of the medical health officer. The Chinese hospital in Victoria was eventually re-built as a nursing home in the 1960s, that now provides elder care for Chinese and non-Chinese patients, offering Chinese food, activities and care in both Chinese and English.<sup>84</sup>

In summary, the history of the Chinese hospital in Victoria indicates that Chinese populations faced harsh public scrutiny from both journalists and sanitary officials. Over time, as Chinese hospitals integrated Western medicine much less criticism occurred. No similar reports were found about the Japanese hospital or Japanese community in the same newspaper during this time period. Yet, in New Westminster, Chinese populations faced the same, if not even more intense criticism as a public health risk.

### **The Chinese Hospital New Westminster**

Chinese citizens in New Westminster experienced regular inspection and public scrutiny by health officials and residents. City council minutes reveal that overcrowding, cleanliness and the burial arrangements of Chinese workers were regularly criticized before council during the 1870s and 1920s.<sup>85</sup> This was due to the belief that Chinese workers living habits contributed to

the spread of disease. Historian of medicine, Charles Rosenberg,<sup>86</sup> argues that contagious disease was still not completely understood at the time and was believed to be caused primarily by “miasma” or “bad air” due to ventilation and crowding in confined spaces. This view was informed by the sanitarian movement in Britain, which focused on eliminating filth and odor due to sewer gases, water waste and urban refuse. Personal and public cleanliness were associated with modernity, civility and progression, whereas dirt, disorder and odor symbolized unenlightened and uncivilized existence.<sup>87</sup> Though scientific bacteriology gained prominence during the 1890s, there was still little consensus about the causes of many diseases, such as plague, typhoid and leprosy.<sup>88</sup>

Within the confines of New Westminster’s Chinatown, crowded conditions and lack of cleanliness were not unusual. One reason for this may be the lack of Chinese women might have contributed to poor living conditions, but likely poverty was the most important factor.<sup>89</sup> City council, concerned about cleanliness and overcrowding, regularly visited Chinatown, ordered cleanings and destroyed Chinese dwellings. Health, disease and treatment were criticized not only by the sanitation officer, hired to uphold sanitation laws, but also by anti-Asian labour groups such as the Knights of Labour.<sup>90</sup>

In June of 1892, W. A. Cumyow requested that the city council provide a lot for a Chinese hospital. From the perspective of the Council, the hospital was little more than a ‘Pest House’ that would separate Chinese men sick with small pox from the hospitals used primarily by White British Columbians.<sup>91</sup> By 1904, plans were made to build a larger hospital, despite petitions from local residents.<sup>92</sup> In 1905, the hospital was constructed at 825 Holbrook Street and Lon Lam worked as the head housekeeper.<sup>93</sup> The Chinese hospital in New Westminster kept two patient registries recording patients’ names, birth places, ages, illness, and grave numbers.<sup>94</sup>

Although the registries are not comprehensive or complete, patient information from 1905 to 1969 is provided. According to these records, the hospital was only used by Chinese patients, and it transitioned from a hospital that treated a wide variety of ages to one that treated primarily elderly or dying patients. The records also reveal that the hospital was used as a funeral home. Many patients were brought to the hospital when they had hours left to live. Often patients were buried in local Chinese-owned cemeteries and grave stone numbers were recorded.

The Chinese Hospital in New Westminster did not escape scrutiny from residents and medical practitioners in the city. In January of 1912, caretakers of the hospital reported:

For many years we have not created any registry books. However, last year there have been some inquiries made by local doctors in some cases where small pox, death by accident or violence happened. In view of this, as well as potential blame of our negligence, we have decided to create registry books.<sup>95</sup>

This entry reveals that the Chinese hospital in New Westminster also faced regular inspection for not being ‘up to’ Western standards. In 1929, the Chinese hospital was incorporated as an ‘Old Man’s Home’ and provided care for elderly Chinese Men until 1975. The building was donated to the city and was demolished in 1979.<sup>96</sup>

The history of the Chinese hospital in New Westminster further demonstrates that Chinese populations in British Columbia faced significant criticism as a public health hazard, especially from sanitation and city officials. Yet, the Chinese hospital served an important function for the community, not only as a place for the sick, but also to provide Chinese residents with cemeteries and funerals that would reflect Chinese traditions.

### **Chinese Cemeteries and Funerals**

Chinese burial practices were important to the local Chinese populations that worked and lived in British Columbia during the turn of the twentieth century. In China, bodies were buried near the family homestead, generally with other ancestors.<sup>97</sup> Ancestor worship in China began as

early as the Bronze Age and encouraged a kinship between the living and dead. Chinese families utilized inscribed tablets with the names of deceased relatives for worship and offerings. Daily prayers, rituals and sacrifices were performed. The yearly celebration *Qingming*, held in April, honored ancestors with food, paper money, and other offerings. Many of these rituals were continued in Canada, but by Western standards at the time, Chinese funerals were viewed as extravagant, imposing and sometimes secretive affairs.

In the Pacific Northwest, local Chinese Benevolent Associations purchased cemeteries and assisted in carrying out Chinese funeral customs. Funeral customs were important to individuals because they believed that traditional rituals would assist the soul onward into the celestial world. Without these rituals it was believed that soul was vulnerable to evil spirits and could bring relatives and friends bad luck. To protect against these ills, bodies were carefully washed and handled to ensure the soul only left the body at the proper moment. Funerals included a large procession in which the body was carried to an airtight coffin. Music and drumming helped ward off evil spirits as the body made its way to its final resting place. After death, the soul was expected to meet *Yan Lao*, the God of Death, and his ten judges who would determine punishments based on the sins committed during life. These underworld magistrates could be bribed if appropriate gifts were provided. Paper items that resembled money and other desirable objects were burnt at the grave site to curry favour with the gods.<sup>98</sup>

In Victoria, the first Chinese cemetery was purchased in 1891.<sup>99</sup> One year later, Chinese residents of New Westminster bought land and a brick furnace for burial rites. In contrast to Western traditions, burial plots were often leased for a period of six years. Bodies were buried for that time and then the grave was disinterred so that the bones could be gathered, cleaned and dried. Bones were considered to be charged with powerful energy, and were hoped by the

deceased to be reburied with ancestors back in China. Once cleaned, bones were carefully packed and labelled in wooden and metal crates, stored in a Bone House, often located at the cemetery itself. In Victoria, the Bone House was located in a wooden building, until a brick building was built in the Chinese cemetery in 1907.<sup>100</sup>

In most cases, Chinese families independently organized a shipment of bones to China. By 1909, the Chinese Benevolent Association in Victoria decided to centralize bone shipping in Canada, to save families shipping costs and simplify the practice. For nearly 30 years, bones were sent across Canada to Victoria for shipping once every seven years. The last shipment to leave Victoria occurred in 1930 due to the Sino-Japanese war in 1937. Further shipments were prevented when the People's Republic of China came to power in 1949.<sup>101</sup> Many of the bone shipments that left Victoria and San Francisco were sent to the Tung Wah Hospital in Hong Kong. The hospital routinely stored the boxes until relatives came to pick them up for a small fee.<sup>102</sup>

Chinese burial practices were subject to regular criticism in several cities along the Pacific Coast. Residents of Victoria, Vancouver and New Westminster regularly complained that Chinese funerals were disruptive affairs. In 1879, a reporter described the funeral of Yip Jack, a rich restaurant keeper on Cormorant Street. At noon, the street was said to be filled with over one thousand Chinese men and a large number of non-Chinese onlookers. A coffin was brought out and was surrounded with food and a number of ceremonies performed. The reporter commented, "The society here appears to be nothing but an offensive and defensive secret organization and has some 300-400 members."<sup>103</sup> Similar reports about Chinese funerals were made throughout the 1880s. For example, in 1884 the funeral of Chen Shu was described as a large procession of observers, many in special ceremonial garments. Music was played and gongs were sounded at

intervals. The procession continued along several streets from Cormorant to Douglas onward down Fisguard Street, then along Government to Fort Street, then finally to Ross Bay Cemetery. Funeral processions continued in Victoria and Vancouver, though ceremonies were often criticized, especially due to the practice of ceremonial burning at the gravesite.<sup>104</sup> In New Westminster funeral processions were made illegal by city council as early as 1884.

### **Mount Saint Joseph's Hospital Vancouver**

Although hospitals run entirely by Chinese Benevolent Associations were subject to fierce criticism, criticism of Chinese-related health services that utilized Western medical science was absent from primary sources. Hospitals, such as Mount Saint Joseph Hospital in Vancouver were later celebrated and supported financially by the wider Vancouver community.<sup>105</sup>

Mount Saint Joseph's history began in the 1920s, though there was a Chinese hospital that existed in Vancouver prior to this, beginning in the early 1900s. Little is known about this early hospital, but it was managed by the Chinese Benevolent society in Vancouver. This early Chinese hospital was listed in local directories from 1905-1907 at 37 Dupont Street (named East Pender after 1904), from 1912-1922 at 106 Pender East.<sup>106</sup>

Mount Saint Joseph hospital was established in 1921, when a request was made by the Catholic bishop Timothy Casey of Vancouver to work with Chinese populations the city.<sup>107</sup> Bishop Casey was concerned about the large number of deaths amongst Chinese residents in Vancouver. On May 2, 1921 four nursing sisters, Marie du Sacre Coeur, Aimee de Jesus, Marie du Saint Redempteur and Marie de St. Georges, were sent from Quebec to open a new mission in Vancouver. The mission was intended to help Chinese citizens in Vancouver, but also to act as a *pied-à-terre* or ‘second lodging’ for Catholic Missionary Sisters travelling between China and Canada.<sup>108</sup>

After staying for six weeks with the Sisters of Providence at St. Paul's Hospital, the nuns rented a small building on Keefer Street, in Vancouver's Chinatown. The house had eight rooms, distributed between three floors and a cellar. On the first floor, there was a parlour, dining room, kitchen and pantry. On the second floor a chapel, storage room, bedroom and on the third floor two more bedrooms. The Sisters decided to open a school for Chinese children, but found it very difficult to recruit Chinese pupils and teachers, as public schools were preferred by Chinese parents.<sup>109</sup> After many different internal and external difficulties, they then turned their attention to sick and impoverished immigrants. For ten years, the missionary sisters provided an 'Oriental Home' which offered shelter and food, sent by the Sisters of Providence from St. Paul's hospital. The work of the Catholic sisters was supported from donations they received by visiting various businesses and associations in Chinatown.<sup>110</sup>

By 1923, the first missionary sisters were replaced by new recruits and they began to utilize the upstairs of the house as a hospital. In 1924, they opened a dispensary and clinic on 236 Campbell Avenue. Although no clinic records exist detailing the type of clientele served, the clinic was targeted towards the Chinese community. The clinic became so busy that the sisters bought a larger house that would serve as a convent and 18-bed missionary hospital. After two more expansions, a three storey building was built in 1927 named the "Saint Joseph's Oriental Hospital." The first floor of the hospital was used for the aged and incurable, the second floor was dedicated entirely to medical and surgical cases. In 1932, a special wing for tuberculosis patients was opened, to make room for patients who previously were cared for by a clinic operated by the United Church.<sup>111</sup>

In 1928, a clinic was opened at 531 Main Street, operated by physician Yip Kew Ghim. Dr. Yip, was the eleventh son of Yip Sang, a prominent businessman and leader in Vancouver's

Chinese Canadian community. Yip Kew Ghim studied at the University of British Columbia,<sup>112</sup> and then at Queens University for his medical degree.<sup>113</sup> Though very few sources exist, Dr. Yip is claimed to be the first Chinese Canadian doctor recognized in Canada and provided both Chinese and Western treatments. He later became involved in the management of the Mount Saint Joseph's hospital.

Land was purchased for a larger hospital (that still exists today), built in 1941 at 3080 Prince Edward. When the hospital was first opened, it was staffed by five nursing sisters, and admitted only 12 patients. As more patients were admitted, the staff was increased to 18 sisters, six doctors and several lay workers. Physician Fred Chu, recalled that at the beginning, the staff primarily delivered babies and removed tonsils. In 1948 the hospital was made a General Hospital, not just for 'Oriental' patients, and occupancy increased. Once hospital insurance was introduced in 1949, the hospital boomed, particularly in terms of elective surgery (e.g. gall bladder, varicose veins). The nursing sisters regularly held bazaars to raise money and add to the list of patient services in the hospital. By 1956, a new wing was added, and later an Intensive Care Unit in 1969. The hospital is still in operation today as an acute community care hospital, as well as a residential home for elderly patients.<sup>114</sup>

## **Summary**

The history of early Chinese hospitals in British Columbia provides an important comparison for the Japanese hospital in British Columbia. Despite shared experiences of anti-Orientalism, Chinese and Japanese communities developed hospitals differently and were perceived in different ways by the broader community at the turn of the twentieth century. Chinatown and Chinese hospitals were often depicted by the public as public health hazards and harbourers of infectious illness, whereas the Japanese hospital faced little public criticism. One

factor that contributed to this difference was the political and economic upheaval in China which left Chinese populations in Canada more vulnerable to unfair public criticism and prejudice.

Another factor was the use of Chinese, rather than Western medicine, and the lack of conformity to Western hospital and public health standards including cleanliness, hygiene and use of trained nurses. The Japanese hospital likely avoided the same type of scrutiny by utilizing Western ideas about medicine, nursing and hospital development. Public criticism of Chinese hospitals subsided as Western medical ideas and practitioners were employed. The history of Mount Saint Joseph's hospital demonstrates that Chinese hospitals were not criticized by the public when they were viewed as charitable institutions offering an integration of Western medicine and Chinese traditions. Mount Saint Joseph's hospital and the Chinese hospital in Victoria still exist today and continue have a mandate to offer specialized care with Chinese cultural preferences in mind. These findings demonstrate that culture and race have and continue to be an important consideration for hospital development in Canada.

<sup>1</sup> Risse, *Plague, Fear and Politics in San Francisco's Chinatown*, 51.

<sup>2</sup> See Li, *The Chinese in Canada*, ch. 2.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid., 18.

<sup>5</sup> David Scott, *China and the International System, 1840-1949: Power, Presence, and Perceptions in a Century of Humiliation* (Ithaca, NY: State University of New York Press, 2008), 51.

<sup>6</sup> David C. Wright, *The History of China* (Westport, CT: Greenwood Press, 2001), 117-120.

<sup>7</sup> Roy, *White Man's Province*, 92-93.

<sup>8</sup> Lai, "Chinese Attempts to Discourage Emigration: Some Findings from the Chinese Archives in Victoria," 43.

<sup>9</sup> See Roy, *White Man's Province*, 157, for examples of how Japanese consul Nosse intervened in the restriction of Japanese immigration to Canada.

<sup>10</sup> Peng Y. Ho and F. Peter Lisowski, *Concepts of Chinese Science and Traditional Health Arts: A Historical Review* (Singapore: World Scientific Publishing, 1993).

<sup>11</sup> Frederick P. Howard and George Barnett, *British Columbian and Victoria Guide and Directory* (Victoria, BC: Howard, Frederick P.; Barnett, George, 1863),

[http://www.vpl.ca/bccd/index.php/browse/title/1863/British\\_Columbia\\_Guide\\_and\\_Directory](http://www.vpl.ca/bccd/index.php/browse/title/1863/British_Columbia_Guide_and_Directory)

<sup>12</sup> Ibid., 69, 82.

<sup>13</sup> University of Victoria Archives, "Lists of Numbers and Occupations of Chinese in British Columbia" Chinese Consolidated Benevolent Association Victoria BC, University of Victoria Archives, ccbav\_4\_3\_001, 1884),

<http://contentdm.library.uvic.ca/cdm/compoundobject/collection/collection2/id/91>

<sup>14</sup> See Kay Anderson, *Vancouver's Chinatown: Racial Discourse in Canada, 1875-1980* (Montreal, QC: McGill - Queen's University Press, 1991), ch. 2.

<sup>15</sup> Lai, *Chinatowns: Towns within Cities in Canada*, 3-4.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid., 4-8.

<sup>18</sup> Vancouver Public Library, *British Columbia City Directories*.

<sup>19</sup> Moxibustion is a traditional Chinese medical therapy in which a small bundle of herbs or 'moxi' is burnt directly on or near the skin at particular points on the body, utilizing heat to promote healing.

<sup>20</sup> Paul D. Buell, "Chinese Medicine on the "Gold Mountain": Tradition, Adaptation, and Change," in *Disease and Medical Care in the Mountain West: Essays on Region, History and Practice*, eds. Martha Hildreth L. and Bruce T. Moran (Reno, NV: University of Nevada Press, 1998), 95-109.; Ho and Lisowski, *Concepts of Chinese Science and Traditional Health Arts: A Historical Review*, 5-60.

<sup>21</sup> According to Henderson's BC Gazetteer and Directory 1890, Wing Pie Lung practiced surgery and bone setting on 144 Government St., 602.

<sup>22</sup> Buell and Muench, "Chinese Medical Recipes from Frontier Seattle," 100-143.

<sup>23</sup> John Adams, "A Chinese Herbalist in British Columbia," *British Columbia Historical News* 21, no. 2 (1988): 7-9.

<sup>24</sup> Cheekugtong (Chinese Freemasons), "Chinese Medical Text" UBC Chung Collection, (University of British Columbia Rare Books and Special Collections, 1860),

<http://digitalcollections.library.ubc.ca/cdm/compoundobject/collection/chung/id/17464/rec/2>

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<sup>25</sup> Buell and Muench, "Chinese Medical Recipes from Frontier Seattle," 100-143.

<sup>26</sup> Ibid.

<sup>27</sup> Adams, "A Chinese Herbalist in British Columbia," 7-9.

<sup>28</sup> See Lai, *Chinatowns: Towns within Cities in Canada*, 7.

<sup>29</sup> Edward Mallandaine, *British Columbia Directory* (Victoria, BC: Mallandaine and Williams, 1887), 308, [http://www.vpl.ca/bccd/index.php/browse/title/1887/British\\_Columbia\\_Directory](http://www.vpl.ca/bccd/index.php/browse/title/1887/British_Columbia_Directory).

<sup>30</sup> The Dan Yock Tong druggist store was first mentioned in the 1884-1885 British Columbia directory at 7 Cormorant Street, then later at 12 Cormorant Street in 1889.

<sup>31</sup> British Columbia Colonist, "Card of Thanks to Dr. Chong," *British Columbia Colonist*, December 22, 1872,

<http://archive.org/stream/dailycolonist18721222uvic/18721222#page/n3/mode/1up>

<sup>32</sup> Buell, *Chinese Medicine on the "Gold Mountain"*, 95-109.; Buell and Muench, "Chinese Medical Recipes from Frontier Seattle," 100-143.

<sup>33</sup> Lai, *Chinatowns*, 4-8.

<sup>34</sup> Victoria Daily Colonist, "Chinese Doctors in the U.S.," *Victoria Daily Colonist*, June 7, 1905, <http://archive.org/stream/dailycolonist19050607uvic/19050607#page/n4/mode/1up>

<sup>35</sup> Ibid., 4.

<sup>36</sup> Victoria Daily Colonist, "Chinese Doctors Prosecuted for Practising," *Victoria Daily Colonist*, Friday, August 21, 1896,

<http://archive.org/stream/dailycolonist18960821uvic/18960821#page/n0/mode/1up>

<sup>37</sup> Mark S. Wade, "Notes on Medical Legislation in British Columbia," Provincial Archives of British Columbia, Accessed September 20, 2013, [http://archive.org/details/cihm\\_16417](http://archive.org/details/cihm_16417)

<sup>38</sup> See Gagan and Gagan, *For Patients of Moderate Means*, ch. 4.

<sup>39</sup> For an example, see Wade, *Notes on Medical Legislation in British Columbia*, 11.

<sup>40</sup> Victoria Daily Colonist, "Chinese Doctors Prosecuted for Practising," 2.

<sup>41</sup> See page LXV of the Canada Royal Commission on Chinese Immigration, *Report of the Royal Commission on Chinese Immigration, 1885* (Ottawa, ON: Printed by order of the commission, 1885), <http://archive.org/details/cu31924023463940>.

<sup>42</sup> Rissee, *Plague, Fear and Politics in San Francisco's Chinatown*, 51.

<sup>43</sup> Ibid., 52.

<sup>44</sup> Roy, *White Man's Province*, 53.

<sup>45</sup> Lai, "The Chinese Consolidated Benevolent Association in Victoria," 53.

<sup>46</sup> Ibid., 60.

<sup>47</sup> Ibid., 56.

<sup>48</sup> Lai, "From Self-Segregation to Integration," 53.

<sup>49</sup> Ibid.

<sup>50</sup> Rissee, *Plague, Fear and Politics in San Francisco's Chinatown*, 51-56

<sup>51</sup> Ibid., 51.

<sup>52</sup> Ibid., 51-52.

<sup>53</sup> Victoria Daily Colonist, "The Chinese Dead House: A Corpse Thrown into the Hospital to Well the Number of the Dead. Sights and Scenes in a Modern Pest Hours - Unsanitary and Foul," *Victoria Daily Colonist*, February 19, 1893,

<http://archive.org/stream/dailycolonist18930219uvic/18930219#page/n5/mode/1up>.

<sup>54</sup> Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley, CA: University of California Press, 2001), 176.

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<sup>55</sup> Robert D. Defries, ed., *Development of Public Health in Canada* (The Canadian Public Health Association, 1940), 99.

<sup>56</sup> See Roy, *White Man's Province*, ch. 2.

<sup>57</sup> Victoria Daily Colonist, "Shocking State of Things," *Victoria Daily Colonist*, December 24, 1892, <http://archive.org/stream/dailycolonist18921224uvic/18921224#page/n6/mode/1up>

<sup>58</sup> Ibid., 8

<sup>59</sup> Ibid.

<sup>60</sup> Ibid.

<sup>61</sup> Roy, *White Man's Province*, 70-71.

<sup>62</sup> Victoria Daily Colonist, "Shocking State of Things."

<sup>63</sup> Lai, "From Self-Segregation to Integration," 54.

<sup>64</sup> Lai, "The Chinese Consolidated Benevolent Association in Victoria," 56.

<sup>65</sup> Victoria Daily Colonist, "Cable News: The Chinese Hospital." *Victoria Daily Colonist*, December 29, 1892,

<http://archive.org/stream/dailycolonist18921229uvic/18921229#page/n0/mode/1up>

<sup>66</sup> Ibid., 1.

<sup>67</sup> Victoria Daily Colonist "Another Dead Chinaman," *Victoria Daily Colonist*, December 31, 1892, <http://archive.org/stream/dailycolonist18921231uvic/18921231#page/n3/mode/1up>

<sup>68</sup> Victoria Daily Colonist, "Unclean Chinatown," *Victoria Daily Colonist*, December 31, 1892, 1892, <http://archive.org/stream/dailycolonist18921231uvic/18921231#page/n3/mode/1up>

<sup>69</sup> Victoria Daily Colonist, "The Chinese Dead House," Victoria Daily Colonist, February 19, 1893, <http://archive.org/stream/dailycolonist18930219uvic/18930219#page/n6/mode/1up>

<sup>70</sup> Victoria Daily Colonist, "The Island of Death," *Victoria Daily Colonist*, June 16, 1895, <http://archive.org/stream/dailycolonist18950616uvic/18950616#page/n2/mode/1up>

<sup>71</sup> Chris Yorath, *A Measure of Value: The Story of the D'Arcy Island Leper Colony* (Victoria, BC: Touch Wood Editions, 2000).

<sup>72</sup> Ibid., 13.

<sup>73</sup> Ibid.

<sup>74</sup> Victoria Daily Colonist, "The Chinese Dead House," 7.

<sup>75</sup> Ibid.

<sup>76</sup> Victoria Daily Colonist, "Who did it?" *Victoria Daily Colonist*, March 5, 1893, <http://archive.org/stream/dailycolonist18930305uvic/18930305#page/n0/mode/1up>; Victoria Daily Colonist, "Board of Aldermen: Sewage Works again Debated - the Chinese Hospital, Pest House and Morgue." *Victoria Daily Colonist*, March 9, 1893, <http://archive.org/stream/dailycolonist18930309uvic/18930309#page/n0/mode/1up>

<sup>77</sup> Victoria Daily Colonist, "More Power to Him," Victoria Daily Colonist, March 8 1893, <http://archive.org/stream/dailycolonist18930308uvic/18930308#page/n0/mode/1up>

<sup>78</sup> Ibid., 4.

<sup>79</sup> Victoria Daily Colonist, "The City Council: Comprehensive Report on Health Matters," *Victoria Daily Colonist*, January 28, 1893,

<http://archive.org/stream/dailycolonist18930128uvic/18930128#page/n3/mode/1up>

<sup>80</sup> Victoria Daily Colonist, "Sanitary Matters: What should be done for the City's Health - the Opinions of Leading Physicians." *Victoria Daily Colonist*, November 23, 1884,

<http://archive.org/stream/dailycolonist18841123uvic/18841123#page/n2/mode/1up>

<sup>81</sup> Victoria Daily Colonist, "City Council Meeting." *Victoria Daily Colonist*, March 23, 1893, <http://archive.org/stream/dailycolonist18930323uvic/18930323#page/n0/mode/1up>

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<sup>82</sup> The Law Society of British Columbia, *British Columbia Reports: Wong Hoy Woon V. Duncan* (Victoria, B.C.: The Province Publishing Company, 1896), accessed September 30, 2013, <http://www.library.ubc.ca/archives/pdfs/bcreports/003.pdf>.

<sup>83</sup> Roy, *White Man's Province*, 36.

<sup>84</sup> Lai, "From Self-Segregation to Integration," 60-67.

<sup>85</sup> New Westminster City Archives, "City Council Minutes." *New Westminster City Archives*, New Westminster BC, 1878-1920, 52401.

<sup>86</sup> Rosenberg, *The Care of Strangers*, 136-141.

<sup>87</sup> Risse, *Plague, Fear and Politics in San Francisco's Chinatown*, 67.

<sup>88</sup> Ibid., 69-70.

<sup>89</sup> Ibid., 72.

<sup>90</sup> New Westminster City Archives, "City Council Minutes."

<sup>91</sup> Ibid.

<sup>92</sup> Ibid.

<sup>93</sup> Henderson Publishing Company, "Henderson's City of Vancouver Directory, Vol. XII" (Vancouver, BC: Henderson Publishing Company, 1905), accessed September 30, 2013, [http://www.vpl.ca/bccd/index.php/browse/title/1905/Henderson%27s\\_City\\_of\\_Vancouver\\_Directory](http://www.vpl.ca/bccd/index.php/browse/title/1905/Henderson%27s_City_of_Vancouver_Directory).

<sup>94</sup> New Westminster City Archives, "Chinese Hospital Records."

<sup>95</sup> Ibid., Patient Book 2, 3.

<sup>96</sup> Ibid.

<sup>97</sup> Risse, *Plague, Fear and Politics in San Francisco's Chinatown*, 56.

<sup>98</sup> Ibid., 56-58.

<sup>99</sup> David Chuenyan Lai, "The Chinese Cemetery in Victoria." *B.C. Studies* 75 (1987): 24-42.

<sup>100</sup> Ibid., 32.

<sup>101</sup> Ibid., 36

<sup>102</sup> Risse, *Plague, Fear and Politics in San Francisco's Chinatown*, 61.

<sup>103</sup> Daily British Colonist, "Chinese Funeral." *Daily British Colonist*, January 5, 1879, accessed November 17, 2014,

<http://archive.org/stream/dailycolonist18790105uvic/18790105#page/n1/mode/1up>

<sup>104</sup> W. J. Dowler, "Chinese Customs," *Victoria Daily Colonist*, sec. Local News, July 25, 1902, accessed November 17, 2014,

<http://archive.org/stream/dailycolonist19020725uvic/19020725#page/n1/mode/1up/search/chines e>

<sup>105</sup> Missionary Sisters of the Immaculate Conception, *25th Anniversary of Mount Saint Joseph Hospital and 50th Anniversary of the Arrival in Vancouver of the Missionary Sisters of the Immaculate Conception* (Vancouver, BC: Mount Saint Joseph Hospital, 1971), 1-14.

<sup>106</sup> See Henderson's Vancouver Directories for these years.

<sup>107</sup> Primary sources for Mount Saint Josephs are located in the Missionary Sister of Immaculate Conception Archives at 100, Place Juge-Desnoyers, Laval Quebec, H7G 1A4.

<sup>108</sup> Turcotte, "Hospitals for Chinese in Canada: Montreal (1918) and Vancouver (1921)," 131-142.; D. Rink, *Spirited Women: A History of Catholic Sisters in British Columbia* (Vancouver, BC: Harbour Publishing, 2000), 165-171.

<sup>109</sup> Ibid., 167.

<sup>110</sup> Ibid., 170.

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<sup>111</sup> Turcotte, “Hospitals for Chinese in Canada: Montreal (1918) and Vancouver (1921),” 131-142.; Quene Yip, *Vancouver Chinatown: 1886-1936* (Vancouver, BC: Pacific Printers, 1936), accessed November 17, 2014,

<http://digitalcollections.library.ubc.ca/cdm/compoundobject/collection/chung/id/18219/rec/6>.

; Rink, *Spirited Women: A History of Catholic Sisters in British Columbia*, 170-171.

<sup>112</sup> The University of British Columbia was founded in 1908, although the point grey campus was not opened until 1915. Only a few Chinese and Japanese students were accepted to study at the University of British Columbia, though it is not clear how many applied and were rejected.

<sup>113</sup> Several artifacts and biographical information related to Kew Ghim Yip can be found at the Museum of Vancouver. See for example, “Dr. Yip Kew’s Journal 1930,” Museum of Vancouver, accessed November 17, 2014, <http://openmov.museumofvancouver.ca/node/94915>

<sup>114</sup> Missionary Sisters of the Immaculate Conception, *25th Anniversary of Mount Saint Joseph Hospital and 50th Anniversary of the Arrival in Vancouver of the Missionary Sisters of the Immaculate Conception*, 1-14.

# **CHAPTER 2: THE ROLE OF METHODIST MISSIONARIES IN THE ESTABLISHMENT OF THE JAPANESE MISSION HOSPITAL, 1893-1899**

*How often speakers and writers quote a line or two from Kipling, as it may suit their purpose:*

*“For east is east and west is west, and never the twain shall meet.”*

*And then proceed to expatiate upon the incurable differences of the Oriental and Occidental races, omitting the following lines, which, if carefully considered and applied, might seem to supply the solution for the very problem at hand:*

*“But there is neither east nor west, border, nor breed, nor birth, when two strong men stand face to face, though they come from the ends of the earth.”*

-Dr. S.S. Osterhout

Superintendent of Oriental Missions West of the Great Lakes, 1922, p. 48

The Japanese hospital established in Steveston during the late 1880s began as a modest mission hospital. Services were first offered in 1896 by a group of Japanese Christians who originated from a small group of Methodist Episcopal missionaries from San Francisco and Seattle in the United States. From 1897 to 1899, the Japanese mission hospital was supported by the Canadian Methodist Church.<sup>1</sup> As the Japanese fishermen became more involved in the use and operation of the hospital, it was decided that a modern hospital would be built in 1900 to replace the mission hospital. This hospital primarily served the needs of the Japanese fishermen, but became important for the entire community in Steveston, operating for forty-one years (1900-1941).

In this chapter, I examine the history of the first few years of the Japanese mission hospital (1896-1899), to understand how Methodist missionaries became involved in the early establishment of the hospital. I attempt to understand the development of the hospital within the

broader context of Canadian Methodist mission work, comparing the Japanese hospital to medical mission work amongst other marginalized groups in British Columbia during the turn of the twentieth century. I begin this chapter by arguing that hospital development became part of the Methodist movement in Canada because Methodist doctrine required participation in evangelism and charitable works. Non-white groups were viewed as part of obsolete or declining civilizations in need of Christian conversion, which would provide both progress and civility. Yet, I argue that medical work among various non-White evangelized groups differed considerably within the Methodist church. An analysis of the health-related missionary work amongst Aboriginal, Chinese and Japanese populations reveals that the Japanese hospital was unique amongst Methodist mission activities during this time period in British Columbia.

The Japanese hospital was a special venture for the Methodist church because it was the only Methodist hospital established and operated by Japanese Christians in Canada and the United States.<sup>2</sup> In contrast, several Aboriginal hospitals were built by Methodist Missionaries, but these were established by missionaries of European descent, with little involvement from Aboriginal peoples. Missionaries who worked in Aboriginal communities promoted the superiority of Western medical science, and discouraged local medical practices.<sup>3</sup> Methodist hospitals were not established specifically for Chinese populations, but Methodist missionaries did provide Chinese Christians access to medical and nursing training in Canadian schools, despite widespread discrimination against non-White students. The history of the development of Japanese mission hospital demonstrates that for many Japanese Christians, conversion meant a bridging of Asian and White identities. Christian conversion resulted in the obtainment of unique social and economic opportunities, like hospital work, which would have otherwise been difficult given the anti-Oriental context of the time.

## **The Influence of the Methodist Movement in Canada**

The history of the involvement of Japanese Christians in hospital development in British Columbia begins with an understanding of the doctrine and history of the Methodist movement in Canada during the 1800s. Methodism, a form of Protestant Christianity, originated from the teachings of brothers John and Charles Wesley in Britain during the late 1700s. The Wesley brothers promoted a new kind of personal spiritual growth, achieved by grace, love and performing good works. They accepted the fundamental principles of Protestantism, such as belief in the authority of the bible and Ten Commandments, but hoped to actively “revive” Protestantism and challenge the perceived apathy and exclusiveness of the Church of England. Methodist followers questioned predestination (the belief that Christian salvation was pre-determined by God) and argued that God willed everyone to be saved, but it was the responsibility of the individual to exercise their free will to accept Christ. As a result, Methodism focused on spirituality at the level of the individual and offered followers a new intimate fellowship, created from a grassroots movement that challenged the top-down approach of the Church of England.<sup>4</sup>

Converts that joined the “Wesleyan” movement became known as “Methodists” because they performed a routine “method” of worship that included prayer, fasting, bible study, communion and good works. Converts were viewed as successful if they actively pronounced their spiritual fervour, worked hard, practiced sobriety and took part in charitable acts such as helping the poor, taking care of the sick, visiting prisoners and assisting widows and orphans. Individuals were expected to not only able to recognize God’s presence, but to be transformed into a new person who would become an agent of God’s love. This meant that those who were truly converted were “Reborn” and obligated to further God’s work with their new lives.<sup>5</sup>

The Methodist's particular approach to evangelism, termed "Revivalism" utilized circuit preachers who organized camp conversions. These travelling preachers were central to the success of the Methodist church both in England and later abroad, in countries like Canada. The Methodist movement not only provided religious guidance, but also the opportunity for socialization in a respectable setting. Though Methodism required the personal pursuit of spiritual growth, followers were bonded in their common pursuit of spiritual fervour and moral virtues. One of the most distinctive aspects of Methodism, as compared to other religions in Canada at the time, was that the emphasis on conversion lessened traditional divisions of class, race and nationality.<sup>6</sup> The shared experience of conversion altered relationships and transformed strangers into equals, despite differences that might have otherwise divided people. This aspect of the Methodist religion is fundamental to understanding why Japanese Methodist Christians would be involved in building a modern medical hospital in Steveston, British Columbia. Conversion to Methodist Christianity allowed racially marginalized groups opportunities that would have otherwise been limited during this time period.

The first Methodist missionaries entered Canada (then British North America) in the 1760s in Newfoundland and spread across to the Maritimes as well as Upper and Lower Canada. The Wesleyan Methodists confined most of their missions to Lower Canada, while Episcopal Methodists occupied missions directed to both White and Aboriginal populations in Upper Canada. By the 1884, several different Methodist churches amalgamated into the Methodist church of Canada, with a total membership that exceeded that of any other Protestant church in Canada.<sup>7</sup>

While the Methodist church eventually undertook foreign mission work in Japan and China, the majority of Methodist mission work actually took place within Canada. These

missions, often termed domestic or “Home Missions” took place in a variety of settings within Canada and were aimed not only at newly arrived European immigrants, but also at groups such as Aboriginal, French, Ukrainian, Italian and Asian populations.<sup>8</sup> The Methodist Missionary Society was established and administered by semi-autonomous missionary superintendents, first in Britain and later under Canada’s national Methodist church, established in 1884. It was the Methodist Mission Society that eventually became involved in the Japanese mission hospital in Steveston.<sup>9</sup>

In 1878, the Methodist Missionary Society oversaw 30 domestic missions (primarily British), 44 Aboriginal missions, 5 German missions, 9 French Missions and 24 other missions in Canada.<sup>10</sup> These missions were spread across pioneer regions of northern Ontario, the Northwestern provinces and British Columbia. In these early years, the missionary societies often incurred financial deficits, but this changed for the Methodist church as immigration in Canada increased during the turn of the century. By 1915, the Methodist Church organized 613 domestic missions, 62 Aboriginal missions, 7 Chinese missions and 5 Japanese missions.<sup>11</sup> During this time, the administration of the Canadian Methodist missions split into two departments: Foreign and Home Missions. The Home Mission department managed the missions which were directed towards European immigrants, including French and city missions. The Foreign Mission department oversaw Home missions amongst Asian and Aboriginal missions because of the need for missionaries with special skills and training, such as the ability to speak several languages and experience with foreign cultures.<sup>12</sup>

Alongside the Methodist Mission Society, the Women’s Missionary Society or WMS began in the 1870s and had an important role in mission operations both within Canada and abroad. This women-led organization independently operated its own missions, personnel and

funds in relation to the wider Methodist Missions Board. The WMS participated in many evangelical, educational and medical missions. As argued by historian Rosemary Gagan, the WMS offered primarily small-town, middle-class women careers that would not have otherwise been available during the time in which they lived.<sup>13</sup> The most coveted positions were those in Japan and China. These positions were filled by the most desirable and educated applicants. In later years, positions in Home Missions in Canada were often filled by those women who had already lived abroad. Language skills were important to the evangelical and charity aspect of home missions. Women who could converse in two or more languages were valuable and often worked as teachers or nurses in Canada, paid by the WMS.<sup>14</sup> Methodist mission work amongst non-White populations differed from, but were influenced by work that originated with Aboriginal populations.

### **Methodist Mission Work in British Columbia amongst non-White Groups**

Methodist mission work in British Columbia began amongst non-White groups as primarily evangelical and educational work because of the emphasis on goals of Christianising and assimilating these populations. During the mid to late 1800s, Methodist missionaries in Canada began to engage in evangelical work amongst Aboriginal populations. Methodist missionaries viewed Aboriginals as a race facing extinction, in need of Christian intervention. Though highly paternalistic and ethnocentric, missionaries believed that if the Aboriginal populations were exposed to Christian teachings and British culture it would help integrate them into ‘modern’ society. Methodist leaders often argued that conversion to Christianity and a morally-based education was a first step towards civilization and social progress. Through the work that began with Aboriginal populations, the relationship between Christianity, education and civilization became basis for mission work amongst non-White groups at home and abroad.<sup>15</sup>

Like Aboriginal populations, Asian populations were framed by many members of the church as ‘obsolete civilizations’ at the turn of the twentieth century. For example, in 1900 a writer of the Methodist Recorder states:

We do not object to these people because they are Chinese or Japanese, it is rather a question of unequal and unfair competition with our own people, at the same time threatening us with the evil influences of an entirely obsolete type of civilization.<sup>16</sup>

Yet, in contrast, other members of the Methodist church held opposing and complex viewpoints of the impact of Asian immigration in Canada. In 1929, Reverend S. Stanley Osterhout published '*Orientals in Canada*' an important study of Asian immigration and Methodist mission work among Asian populations during this time period.<sup>17</sup> Osterhout, who was born in Ontario on June 30, 1868, worked as a teacher, missionary and administrator within the Methodist Church of Canada over the span of several decades. He was well educated, holding both a Master’s of Arts and Doctorate from Illinois Wesleyan College. He was Superintendent of Oriental Missions in Western Canada in 1911 and held the position until 1939. Osterhout publically opposed the prejudiced treatment of Japanese and Chinese Canadians by the Canadian government throughout his life. His book reveals several important insights about how Methodist missionaries viewed the ‘Oriental Problem’ in British Columbia.<sup>18</sup>

From the perspective of Osterhout, Asian populations were argued to be biologically equal, in that there were no biological deficits in intellectual or physical abilities. However, from Osterhout’s standpoint, immigration policies were unfair and assimilation was viewed as the ultimate objective for Asian immigrants to live in peace and harmony with other groups in Canada. Osterhout argued that it was not surprising for Japanese and Chinese groups in British Columbia to establish schools and newspapers in their native languages because of the fear that sooner or later they may be ejected from Canada. In regards to the problem of language and

ghettoization, Osterhout supported new immigration legislation that would stipulate only foreign born immigrants with speaking and writing knowledge of English be allowed to enter. In response to arguments that Asian populations presented unfair competition in labour, he offered assimilation and Christian teaching as solutions. Osterhout argued that the Christian church ought to take a leadership role in ensuring assimilation and promoting peace amongst the world's races. To achieve this goal he suggested that the Dominion of Canada itself maintain the high moral standards it claimed to uphold, to diffuse the suggestion of subterfuge and unfairness experienced by Oriental groups.<sup>19</sup>

The remainder of Osterhout's work outlines the involvement of various missionaries amongst various Asian communities. He discusses the establishment of schools, missions and churches across Canada, often highlighting the stories of Chinese and Japanese missionaries, ministers and those who achieved a distinguished professional life, such as doctors, teachers and those involved in higher education. Osterhout's work demonstrates that the Methodist church became an important institution for non-White populations to gain access to opportunities that might otherwise have been impossible given the prejudiced context of the time. While underpinned by ethnocentric ideas, the link between assimilation and Christian conversion provided non-White groups with a paradoxical platform from which to infiltrate and contradict racist and discriminatory practices. Many non-White individuals were then only able to combat larger discriminatory policies once they demonstrated they were capable of assimilation. Yet mission work amongst Aboriginal, Chinese and Japanese populations in Canada varied substantially, especially with regard to medical work and hospital development.

## **Methodist Mission Work amongst Aboriginal Populations**

The first Methodist mission work amongst Aboriginal populations in British Columbia occurred in the North-Western portion of the province. Aboriginal mission work began as early as 1858, when several missionaries were sent by the Canadian Wesleyan church to Victoria, visiting communities all along the Fraser river. By 1875, Aboriginal missions were present in Victoria, Nanaimo, Sumas, Burrard Inlet, Chilliwack and Port Simpson. Two influential Methodist missionaries working amongst Northern peoples were Thomas and Emma Crosby, who opened an orphanage for Aboriginal girls in 1880.<sup>20</sup> Thomas Crosby also travelled extensively along the coast, visiting various isolated Aboriginal and European villages.<sup>21</sup> A residential school named the Coqualeetza Institute was opened in Chilliwack in 1887 aimed at educating and assimilating young Aboriginal girls and boys.<sup>22</sup>

Methodist medical missions were established for five different Aboriginal communities, including Port Simpson, Bella Bella, River's Inlet, Port Essington, and Hazelton. The physicians who established these hospitals built, owned and operated the hospitals, although funding support was received from the Methodist church, local communities and provincial government. Nurses that were employed at the hospitals were paid for by the Women's Missionary Society (WMS). However, Aboriginal peoples themselves had little involvement in the establishment or work within the hospitals, often only employed as translators or auxiliary staff until much later in the twentieth century. Unlike the Japanese hospital in Steveston, Aboriginal hospitals were controlled exclusively by White missionary doctors and nurses.<sup>23</sup>

The first medical services for Aboriginal populations were established in Port Simpson by physician Albert Edward Bolton in 1889. A hospital was erected two years later, with financial assistance from the Hudson Bay Company and the Provincial government. By 1890, the

sick and injured came from many parts of the Northern British Columbia to be cared for in the hospital. A nursing-training school was founded in 1891 and graduate nurses were utilized for labour within the other church hospitals across the province. Each summer doctor Bolton and several nurses would travel of Port Essington, near the mouth of the Skeena River to provide medical services to the hundreds of workers who came to the area during the fishing season.<sup>24</sup>

Bolton also travelled along the central coast in a steamer with Thomas Crosby, to visit Aboriginal villages, logging and cannery communities in need of medical care. A summer hospital was erected in 1897 mid-way between Port Simpson and Vancouver at River's inlet. Doctor Bolton and two nurses, Spence and Crosby, provided medical services to nearly three thousand patients during the fishing season. The success of the summer hospital at Rivers Inlet led to the establishment a permanent hospital at the nearby Aboriginal community of Bella Bella, although operations at Rivers Inlet continued each fishing season.<sup>25</sup>

J.A. Jackson was the first physician responsible for medical work at the permanent Rivers Inlet summer hospital and at the medical mission in Bella Bella in July of 1897. One year later he suffered a heart attack and was replaced by physician Richard Whitfield Large. Large was the son of Methodist Minister Rev. Richard Large and had graduated from Trinity Medical College in Toronto. Large first began work in Steveston amongst the Japanese fishermen, until he passed the provincial medical exam and became a permanent doctor at Bella Bella.<sup>26</sup> He continued work at Rivers Inlet and Bella Bella until 1910.<sup>27</sup>

Details about the medical work of R.W. Large, in a publication titled *Drums and Scalpel* reveals that many of these early medical men acted as both doctors and ministers, but also as community leaders.<sup>28</sup> Large practiced medicine throughout the week, but preached on Sundays and often tended to cases of drunkenness to promote Methodist Christian ideals, such as sobriety.

Medical Methodist missionaries also were involved in upholding Western medicine as superior to Aboriginal practices. In the publication about his life, Large characterizes Aboriginal medicine men as charlatans and superstitious.<sup>29</sup> He discusses several attempts to intercept and discouraged local medical practices. As argued by historian Mary-Ellen Kelm, Euro-Canadians promoted the superiority of Western medicine practices, which in turn upheld Euro-Canadian ideals of health.<sup>30</sup> Kelm claims that Aboriginal communities were often regarded by Western medical personnel as filthy, diseased and below Euro-Canadian standards. However, Aboriginal medical practices continued alongside and sometimes in tandem with Western practices, particularly in cases of incurable or chronic disease.<sup>31</sup>

### **Methodist Mission Work amongst Chinese Populations**

The first Methodist mission dedicated to work amongst Chinese populations occurred in New Westminster in 1859. Rev. Edward White began a mission in the city and established a night school to help young boys and men to increase their knowledge of English and encourage contact between Chinese workers and Methodist missionaries.<sup>32</sup> In Victoria, a similar school was established during the late 1860s. In 1873, the Chinese mission in Victoria was renamed the ‘Sanford Mission’ because of a generous yearly donation made by philanthropist and Senator W.E. Sanford.<sup>33</sup> A Sunday school was opened and at times as many as ninety boys came to learn English.<sup>34</sup> Several of these students were evangelized and later contributed to the cause of the mission.<sup>35</sup>

By 1885, the Chinese mission in Victoria consolidated all evangelical efforts under John Gardiner, a man who often acted as an interpreter having grown up the son of a missionary in China. In 1890, he helped to arrange for the establishment of a formal Chinese mission building. Gardiner utilized the mission to end the trafficking of young girls as prostitutes as well as close

gambling dens and opium joints. To support his efforts, the Methodist Women's Missionary Society established a Girls Rescue Home in Victoria in 1887. The Home operated as both a school and boarding house for girls sold into brothels or slavery.<sup>36</sup>

Mission work amongst Chinese populations in Victoria continued under the supervision of several Chinese ministers during the 1910s and 1920s. Methodist mission work amongst Chinese populations in British Columbia excluded hospital development, focusing primarily evangelical, educational and assimilation work. Chinese missions were established in Vancouver, Nanaimo, Kamloops and many other cities across Canada.<sup>37</sup> It is likely that the Methodist Church did not establish Chinese-focused Hospitals because Chinese Benevolent Associations had already taken on this role during the late 1880s. However, Methodist missionaries did play a role in countering discrimination against young Chinese students wishing to enter medical and nursing schools in Canada. Educational missions, like the Girls Rescue Home, provided young women the educational background, references and connections necessary to successfully apply to nursing and medical schools within Canada.<sup>38</sup>

One of the first Chinese nurses educated in Canada was Agnes Chan. Agnes or 'Fung Chan' was one of five sisters born in Southern China in the late 1890s. As a young child, Agnes was sold to a family friend of her father. She stayed with the family for two years, but was eventually sold to a woman in Victoria, British Columbia. Unfortunately, many Chinese girls sold to owners in North America were forced into prostitution or slavery. Once Agnes began her new life in Victoria, it was not long before she fled to the Methodist Women's Rescue Home. Agnes later became a Christian and was educated at the mission school. As her schooling progressed, Agnes learned that her parents had sold her youngest sister in similar circumstances. She informed the missionary workers of the situation and was granted a small amount of money

to free her sister, if she agreed to repay the missionaries when she had graduated and found employment.<sup>39</sup>

Agnes graduated from the mission school in 1920 and applied to several nursing schools in Western Canada. All of her attempts to train were initially declined. According to nursing historian Kathryn McPherson, nursing schools across Canada largely discriminated against Asian students until the 1930s and 1940s.<sup>40</sup> At the time, nursing schools required potential candidates to not only supply impeccable references, but to provide an argument for how they would find future employment. Despite the racist context of the time, non-White women like Agnes could resist discrimination with sufficient support from missionary connections. Through her connections at the mission, arrangements were made for Agnes to attend the Women's College Hospital<sup>41</sup> in Toronto from which she graduated with honours in 1923. Agnes worked at a Methodist Hospital in Southern China until after the Second World War.<sup>42</sup>

Many other Chinese men and women were able to attend Canadian medical schools through their missionary contacts. Victoria Cheung, the daughter of Christian Methodists, is often described as the first female Chinese-Canadian doctor. Victoria's mother had been trained as a midwife in China, and when the family moved to Canada, Victoria was sent to the Oriental Home in Victoria for schooling. Recognized as a bright and capable student, she was chosen to teach Sunday school and also participated in several girls groups at the mission school. As Victoria progressed, she began to make plans to become a missionary in China. Once she graduated from high school, Victoria received a scholarship from the president of the Presbyterian Women's Missionary Society. Arrangements were made for her to attend medical school at the University of Toronto in 1917.<sup>43</sup>

In 1922, Victoria graduated from medical school and interned at Toronto General Hospital. In 1923, she obtained a position through the Presbyterian Women's Missionary Society South China mission. Victoria worked as a physician at the mission for 43 years at the Marion Barclay Hospital. Victoria, Agnes, and other Chinese Canadian physicians, like Dr. Edward B. Gung and Dr. Philip Chu were utilized as examples of success in Methodist missionary literature. They were described as "capable of Canadianization" and celebrated as models of how Christianity alone could "unite the world as kin."<sup>44</sup> These views could be perceived as far less altruistic in today's context of multiculturalism. Nevertheless, the Methodist church did provide opportunities for racially marginalized youth that would have otherwise been impossible. Though Methodist missionaries did not build hospitals for Chinese populations in British Columbia, they did play an important role in the education of young Chinese students in nursing and medical sciences.

### **Methodist Mission Work amongst Japanese Populations**

Japanese Methodist missions in British Columbia were unlike both Aboriginal and Chinese missions because they were established and maintained primarily by Japanese Christians. The history of these missions disrupts the popular notion that missionaries of European descent alone supported the close relationship between Christianization and assimilation.<sup>45</sup> In the case of the Japanese missions, assimilation was supported and discrimination was combated through a number of activities including school development, legal action (for naturalization and franchise) as well as hospital development. Japanese Christians utilized and supported Western ideas and practices and took important steps to fight discrimination, racism and prejudice against Japanese populations within Canadian institutions.

The first Japanese mission in British Columbia was established in Vancouver as a ‘Christian Endeavor’ or *Kyorei-Kwai* aimed at evangelizing and teaching English to fellow Japanese in the city. Although several Japanese Methodist missionaries had entered British Columbia previously through the United States, it was Mr. Shinkichi Temura who organized the first *Kyorei-Kwai* in Vancouver. The English school was open Monday through Friday and was promoted as a way to improve the status of Japanese men and women in Canada. To ensure the longevity of the group Mr. Temura invited Rev. Goro Kaburagi, a member of the Episcopal Church in Ohio to become a permanent missionary in Vancouver.<sup>46</sup>

In 1896, Goro Kaburagi arrived in Vancouver and became the first Japanese Methodist missionary paid by the Canadian Methodist church. Kaburagi was born to an upper class family in 1854, in Katori, Chiba prefecture, Japan. He was well-educated and received a degree at the Imperial College of Forestry in Tokyo, a Bachelor of Science at Northwestern University and a Master of Arts at the University of Iowa. He also became an ordained minister in Columbus, Ohio, through the Methodist Episcopal Church. Once he arrived in British Columbia, he worked as superintendent of the Japanese missions and continued the work of the *Kyorei-Kwai*.<sup>47</sup>

Kaburagi proved to be a very valuable missionary to the Canadian Methodist Church. Not only did he help to triple the membership at the Japanese Vancouver mission in three years, but he also established the first Japanese language paper that was distributed to Japanese communities across the province. Kaburagi also established a boarding home and school for young Japanese men. Several of these students were assisted to attend the Columbian Methodist College in New Westminster to complete high school. Kaburagi assisted Kozo Shimotakahara to go on to medical school at the University of Chicago. He also helped Tomekichi Yokoyama earn a Doctorate of Philosophy and Kotoku Imachi a Doctorate of Literature. In 1906, the Japanese

Methodist Church and night school residence were erected on Powell Street in Vancouver's "Japantown." The night school was operated by Japanese Christians, but also by teachers appointed by the Women's Missionary Society. Missions were established in other Japanese communities including Union (Cumberland), Victoria and Steveston. Those involved in church and school mission work continued towards their goal of assimilating and raising the moral standard of the Japanese in British Columbia. The only medical mission in British Columbia established specifically for Japanese populations was the Japanese mission hospital that was built in 1896 in the fishing village of Steveston.<sup>48</sup>

### **The Establishment of the Japanese Mission Hospital**

The first Japanese hospital in British Columbia began as a mission that was converted into a make-shift hospital following an outbreak of typhoid fever among the Japanese fishermen in Steveston. The mission, which was essentially a building constructed for the purposes of worship, bible study, Sunday services and other evangelist activities, was established by Japanese Methodist missionaries who were influenced by Reverend Otis Gibson, who had already founded a small Chinese mission in San Francisco, California during the 1870s. A separate Japanese mission was built in San Francisco with the help of Reverend Merriam Colbert Harris, Superintendent of the California Conference of the Missionary Society of the Methodist Episcopal Church.<sup>49</sup> Reverend Harris worked as a missionary in Japan during the 1870s and 80s, but after his wife became ill, he moved back to California to work as a missionary amongst the Japanese in 1886. During this time, he evangelized several young Japanese men. One of these young men, Kanichi Miyama, began a small bible study and went on to establish the Japanese Methodist Church in San Francisco. Within a few years, over three hundred Japanese people were baptized. In 1892, plans were made to send a young Japanese missionary, Reverend

Teikichi Kawabe, to evangelize Japanese communities in Oregon, Idaho, Washington, Wyoming and British Columbia. Under his tutelage, several Japanese missionaries would venture north to Canada.<sup>50</sup>

During his first trip to Seattle, Reverend Kawabe convinced several Japanese youth to leave their businesses and attend seminaries. Kawabe encouraged a missionary, Matsutaro Okamoto, to travel to British Columbia to visit the many salmon fishing villages that were occupied by Japanese workers. From 1893 to 1895, Okamoto travelled along the coast, visiting Japanese labourers in Steveston and at the Skeena river canneries in Northern British Columbia. He was paid by the Methodist Episcopal Church for two years, but then he lived in a tent and supported himself by doing laundry work. He later became known as the “Apostle of the Japanese in British Columbia” due of his efforts at the two largest Japanese settlements. After his death, he was celebrated within Methodist literature as a hero.<sup>51</sup>

While Okamoto obtained several followers during his missionary work, he returned to Vancouver in 1895 to receive treatment for tuberculosis. At about the same time Dr. Umetaro Yamamura, a dentist, and Seinosuke Oishi, a medical doctor, travelled from Portland, Oregon to visit the Japanese community in Steveston. During their visit, they were appalled by the immoral behaviour of the men at the Steveston canneries, arguing that they were in need of Christian intervention because of the gambling, drinking, fighting and prostitution that took place amongst the Japanese fishermen. In partnership with Rev. Okamoto they decided that a mission should be built for the Japanese fishermen. Okamoto argued that efforts to Christianize the primarily Buddhist fishermen may be more easily achieved by first demonstrating God’s love through building a hospital.<sup>52</sup>

Okamoto first expressed his desire for a Japanese mission to be established in Steveston in 1895.<sup>53</sup> A small building was erected in 1896 with help from the leader of the Japanese fishermen. A plot of land was made available on the grounds of the Phoenix cannery. Financial support was gained from the Japanese consulate to buy materials and pay for labour. As soon as the church was opened, it was filled with sick men who had consumed contaminated water. Two missionaries Mr. Koichi Inaka<sup>54</sup> and Mr. Ukichi Oyama, volunteered to nurse the men back to health. To convince the men of their sincerity for Christianity, the missionaries worked at the mission without pay.<sup>55</sup>

The first year of hospital operations were supported through donations from the local Japanese community, but the hospital missionaries were left with a debt of \$220. In 1897, expenses rose to \$740.40, with over \$2000 dollars invested overall. The hospital workers had treated about forty patients a year, with the majority staying an average of 4.5 weeks. Due to the success of hospital operations amongst the Japanese fishermen, Japanese leaders began to make plans to repay the hospital debts.

Hospital mission workers like Mr. Inaka were provided many opportunities for joining the Methodist church and demonstrating loyalty and sincerity for the church. Mr. Inaka was born near Kanazawa Japan in 1875, arriving in British Columbia in 1892. He was raised Buddhist, but became Christian in Vancouver under the influence of Rev. Temura and Mr. Okamoto. His work as a volunteer nurse at the Japanese hospital was publically acknowledged and celebrated in the Annual Methodist Missionary report,<sup>56</sup> Methodist Recorder,<sup>57</sup> and provincial newspaper.<sup>58</sup> Mr. Inaka's work garnered him further education in Tokyo and work as a missionary in Victoria. The Japanese missionaries were rewarded with upward mobility socially and careers opportunities,

that would have been difficult to obtain in the context of prejudice that characterized the turn of the twentieth century.

Similar opportunities were provided to lay evangelist Mr. Ukicki Oyama, who was offered work at the Japanese Methodist Mission in Victoria from 1902 to 1906. Oyama also established a new mission in Cumberland, working there until 1913. Oyama, who was born in 1867 in Shiyo-mura, Kagochima Japan, came to Canada in 1888, a member of the samurai nobility in Japan. After his service as a missionary in British Columbia, he briefly worked as an English and Japanese teacher among the Japanese in Southern Alberta (at Raymond and Welling) from 1928 to 1930. Through his connections within the Methodist church he was able to successfully enter his daughter Grace (Sakae) into nursing training at the Methodist hospital in Lamont, Alberta. She returned to Vancouver to work in the Japanese community on Powell Street.<sup>59</sup> Women too could benefit from upward mobility through their connections with the Methodist church.

A diary of one of Vancouver's Japanese Methodist ministers, Rev. Kosaburo Shimizu, reveals that Japanese Christians were viewed quite differently than their non-Christian counterparts. He describes an incident:

A little boy eight years old, came to me and asked, "What are we going to play tonight?" I told him that I couldn't play because I had to go to church. The little boy said, "Going to church? You are civilized aren't you?" So I really pondered over whether going to church reveals one's character. Even though he is a small child, he said something important. Thinking it over, I cannot lightly ignore what he said.<sup>60</sup>

Kosaburo's comment reveals that Christian conversion provided a powerful new identity for Japanese populations. This new identity was congruent with dominant Western and Christian values, which were also perceived to be more civilized.

Although Christianity offered opportunities that would have otherwise been difficult, Japanese Christians often experienced conflict in their new identities. Kosaburo himself was repulsed by the racism he experienced, yet also discouraged at how many of his fellow countrymen disregarded opportunities like education in Canada. Kosaburo himself was continually pressured by his family to work and send money home to fulfill his duties as heir, while also desiring to go to university and make a new life for himself. Kosaburo's identity as a Japanese Christian was challenged, shaped and at times came into conflict with the opportunities and relationships he built working within the Methodist church and Japanese-Canadian community.<sup>61</sup> Shimizu eventually became minister of the Japanese United Church in Vancouver in 1927, two years after the Methodist Church combined with Presbyterian and Congregationalist churches to form the United Church of Canada. Shimizu served there until the internment during World War II in 1942. Shimizu often worked to better relations calling himself a "Go-Between" for Japanese Canadians and fellow citizens. He believed that dedicating one's existence to educating both Japanese and White or *Hakujin* people about each other would help to diminish and eventually eliminate exclusion arguments.<sup>62</sup>

### **Steveston's First Missionary Physician**

While the Japanese mission hospital was able to operate for the first two years with the help of Japanese volunteers, community members in Steveston began to inquire about the possibility of a trained medical doctor to work at the mission hospital. Arrangements were made to hire a Japanese physician, Dr. Soga, from San Francisco. Allegedly, however, Dr. Soga was prosecuted for violating provincial medical law, although the details of the case remain unknown due to a lack of sources.<sup>63</sup>

After this initial disappointment, a request was made through connections within the Methodist Church of Canada to employ a medical missionary to work in Steveston.<sup>64</sup> In 1898, physician Richard Whitfield Large was hired to work for the summers of 1898 and 1899. Dr. Large was born in Kincardine, Ontario in 1873, trained as a Missionary, and educated as a medical doctor at Trinity Medical College at the University of Toronto. At the young age of 25, he was responsible for the care of twelve or more patients at the Japanese mission hospital, as well as walk-in visits, emergencies and surgical cases.<sup>65</sup> Religious meetings were frequently held at the hospital and when the summer was over, the mission was used as a school for bible study. Dr. Large left to work as a medical missionary during the winter in northern British Columbia at Bella Bella.<sup>66</sup>

On Monday, May 22, 1899, Dr. Large married Miss Bella M. Geddes of Toronto and both spent the summer months working in Steveston.<sup>67</sup> Mrs. Large assisted with surgery by delivering anaesthetic, even though she was classically trained in music, rather than medicine.<sup>68</sup> Dr. Large's work was highlighted in the annual Methodist Missionary Society report.<sup>69</sup> Dr. Large made over 600 hospital calls, in addition to visiting sick Japanese patients in their homes. The Japanese fisherman contributed over \$987 for the hospital, but it was clear that a larger hospital would be required to meet the increasing demand. With the loss of Dr. Large permanently to Bella Bella, and increasing racism in the fishing industry and ever-more Japanese entering the region, Japanese leaders became even more determined to establish a hospital of their own. With the loss of support from the Methodist church and Dr. Large, community leaders hoped that the Japanese fishermen might adopt the hospital as an initiative of their own.

## **Summary**

Methodist missionaries played an important role in the development of health services for Asian populations in British Columbia. Examination of Methodist history reveals that charitable work, in the form of education and health care, was a fundamental aspect of Methodist doctrine. However, Methodist missionaries viewed non-White groups as obsolete or declining civilizations in need of Christian intervention and assimilation. From a paternalistic and ethnocentric viewpoint, missionaries believed non-White populations who were exposed to Christian teachings and British culture would be helped to integrate into a ‘modern’ and ‘civilized’ society. Although mission work amongst non-White groups in Canada was founded on these same principles, health care development amongst Aboriginal, Chinese and Japanese populations differed significantly. Hospitals were created for Aboriginal population in remote Northern communities, but Aboriginal populations themselves had little involvement in day-to-day operations. No hospitals were established for Chinese communities, yet Methodist missionaries helped Chinese students obtain education in medical sciences. The Japanese mission hospital in Steveston was a unique enterprise within the Methodist church because it originated from Japanese Christians themselves. Christianity offered non-White groups opportunities that would have otherwise been difficult during the anti-Oriental context of the time. Despite efforts to operate the hospital entirely with Japanese staff, White medical missionaries were utilized to help with hospital operations. It was not long however, until plans were developed to encourage the Japanese fishermen to replace the mission hospital with a new and modern hospital in Steveston.

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<sup>1</sup> The Methodist church would later amalgamate with Congregational Union of Canada and the Presbyterian Church in Canada to form The United Church of Canada in 1925.

<sup>2</sup> There were two other Japanese hospitals established, including one in Hawaii and one in Los Angeles, but sources suggest these were established by Japanese medical doctors, rather than missionaries. See Brian Niiya, ed., *Japanese American History: An A-to-Z Reference from 1868 to the Present* (New York: The Japanese American National Museum, 1993).

<sup>3</sup> Richard Geddes Large, *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast* (Mitchell Press, 1968).

<sup>4</sup> See Semple, *The Lord's Dominion: The History of Canadian Methodism*, ch. 1; Phyllis D. Airhart, *Serving the Present Age: Revivalism, Progressivism, and the Methodist Tradition in Canada* (Montreal, QC: McGill-Queen's University Press, 1992), ch. 1.

<sup>5</sup> Ibid., 14-18.

<sup>6</sup> Ibid., 26.

<sup>7</sup> Ibid., see ch. 4.

<sup>8</sup> Ibid., see ch. 11.

<sup>9</sup> Ibid., 302.

<sup>10</sup> Ibid., 277.

<sup>11</sup> Ibid., 279.

<sup>12</sup> Ibid., 279.

<sup>13</sup> R. Gagan, *A Sensitive Independence: Canadian Methodist Women Missionaries in Canada and the Orient, 1881-1925* (Montreal, QC: McGill - Queen's University Press, 1992).

<sup>14</sup> Ibid., see ch. 2.

<sup>15</sup> Semple, *The Lord's Dominion*, ch. 11.

<sup>16</sup> Methodist Recorder, "Oriental," *Methodist Recorder* (June, 1900b): 14.

<sup>17</sup> Osterhout, *Orientals in Canada*.

<sup>18</sup> Ibid., 4-16.

<sup>19</sup> Ibid., 4.

<sup>20</sup> Jan Hare and Jean Barman, *Good Intentions Gone Awry: Emma Crosby and the Methodist Mission on the Northwest Coast* (Vancouver, BC: University of British Columbia, 2006), xxii.

<sup>21</sup> Bob Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals* (Madeira Park, BC: Harbour Publishing, 2004), 18.

<sup>22</sup> Semple, *The Lord's Dominion*, 295.

<sup>23</sup> See examples in Burrows, *Healing in the Wilderness*.

<sup>24</sup> Ibid., 19-23.

<sup>25</sup> Ibid., 23

<sup>26</sup> Richard Whitfield Large's work at Steveston is discussed later in this chapter.

<sup>27</sup> Ibid., 23-25.

<sup>28</sup> Richard Geddes Large, *Drums and Scalpel*.

<sup>29</sup> Ibid., 65-81.

<sup>30</sup> Kelm, *Colonizing Bodies*.

<sup>31</sup> Ibid., 129.

<sup>32</sup> Osterhout, *Orientals in Canada*, 70.

<sup>33</sup> Ebenezer Robson, *How Methodism came to British Columbia* (Toronto, ON: Methodist Young People's Forward Movement for Missions, 1904), 26, accessed November 17, 2014, [http://archive.org/details/cihm\\_75905](http://archive.org/details/cihm_75905)

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- <sup>34</sup> Ibid, 26.
- <sup>35</sup> Osterhout, *Orientals in Canada*, 74.
- <sup>36</sup> Ibid., 74-77.
- <sup>37</sup> Ibid., see ch. 4.
- <sup>38</sup> Ibid., see ch. 8.
- <sup>39</sup> All records related to Agnes Chan were obtained from the Women's College Hospital Archives in Toronto, Canada. No fonds or file numbers were provided.
- <sup>40</sup> McPherson, *Bedside Matters*, 210.
- <sup>41</sup> The college was opened in 1883 in response to all women being excluded from other medical schools in Toronto. There does not seem to be any connection to the Methodist Church.
- <sup>42</sup> Women's College Hospital Archives in Toronto, Canada, see note above.
- <sup>43</sup> Deborah Shulman, "From the Pages of Three Ladies: Canadian Women Missionaries in Republican China" (Master of Arts, Concordia University, 1996), 120, accessed November 17, 2014, <http://spectrum.library.concordia.ca/155/1/MM18443.pdf>
- <sup>44</sup> Osterhout, *Orientals in Canada*, 110.
- <sup>45</sup> See for example, Wang, *His Dominion and the "Yellow Peril"*.
- <sup>46</sup> Osterhout, *Orientals in Canada*, see ch. 7.
- <sup>47</sup> S. S. Osterhout, "The Passing of an Apostle," *The Western Recorder* 2, no. 1 (July, 1926): 6.
- <sup>48</sup> See Kawano, *A History of the Japanese Congregations of the United Church of Canada, 1892-1959*.
- <sup>49</sup> Methodist Episcopal Church Missionary Society, *Seventy-First Annual Report of the Missionary Society of the Methodist Episcopal Church for the Year 1889* (New York: The Society, 1890), accessed November 17, 2014.,  
<https://play.google.com/store/books/details?id=vLAPAAAAIAAAJ>
- <sup>50</sup> Ibid., 345-348.
- <sup>51</sup> Osterhout, *Orientals in Canada*, see ch. 7; Kawano, *A History of the Japanese Congregations of the United Church of Canada, 1892-1959*.
- <sup>52</sup> Tadashi Mitsui, "The Ministry of the United Church of Canada amongst Japanese Canadian in British Columbia 1892-1949" (Master of Sacred Theology, Union College of British Columbia), see ch. 1.
- <sup>53</sup> Methodist Church, *Minutes of the Proceedings of the Ninth Session of the British Columbia Conference of the Methodist Church: Mr. Okamoto's Report* (Toronto, ON: William Briggs, 1895), accessed November 17, 2014, [http://archive.org/details/cihm\\_15632](http://archive.org/details/cihm_15632)
- <sup>54</sup> His name was written 'Koichi Ichu' in much of the Methodist literature.
- <sup>55</sup> Victoria Daily Colonist, "Vancouver's Japanese Mission." *Victoria Daily Colonist*, sec. News of the Province, October 7, 1897, accessed November 17, 2014,  
<http://archive.org/stream/dailycolonist18971007uvic/18971007#page/n2/mode/1up>
- <sup>56</sup> Goro Kaburagi, *Japanese Work, British Columbia, Steveston, Annual Report of the Methodist Mission Society 1898* (Toronto, ON: Methodist Mission Rooms, 1898).
- <sup>57</sup> W.H.B., "Koich Ichu San," *Western Methodist Recorder* 1, no. 9 (March, 1900): 1.
- <sup>58</sup> Victoria Daily Colonist, "Vancouver's Japanese Mission."
- <sup>59</sup> Ukichi Oyama, "Biographical File," Bob Stewart Archives, UBC.
- <sup>60</sup> Kosaburo Shimizu: *The Early Diaries, 1909-1926*, ed. Grace Arai, trans. Tsuguo Arai (Anchorage, Alaska: AT Publishing, 2005), 62.
- <sup>61</sup> Ibid.
- <sup>62</sup> Ibid., 390.

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<sup>63</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 48-50.

<sup>64</sup> Methodist Church, *Minutes of the Proceedings of the Twelfth Session of the British Columbia Annual Conference of the Methodist Church* (Toronto, ON: Briggs, W., 1898), 51, accessed November 17, 2014, [http://archive.org/stream/cihm\\_15634a#page/n3/mode/2up](http://archive.org/stream/cihm_15634a#page/n3/mode/2up)

<sup>65</sup> Bob Stewart Archives, Dr. Richard Whitfield Large, "Biographical File," Bob Stewart Archives, University of British Columbia. These records are without file numbers.

<sup>66</sup> Ibid.

<sup>67</sup> Methodist Recorder, "Marriages: Large-Geddes." *Methodist Recorder* 1, no. 1 (July, 1899).

<sup>68</sup> Photos of the Large's time in Steveston can be found in the Richmond City Archives, Richmond, BC, including a photo of the first surgery conducted by Dr. Large and assisted by his wife. Mrs. Large's marriage announcement reveals she was a Fellow of the Toronto Conservatory of Music (FTCM).

<sup>69</sup> Methodist Church, *Seventy-Sixth Annual Report of the Missionary Society of the Methodist Church* (Toronto, ON: Methodist Mission Rooms, 1899).

# **CHAPTER 3: FROM METHODIST MISSION TO MODERN HOSPITAL: THE EARLY DEVELOPMENT OF THE JAPANESE FISHERMEN'S HOSPITAL**

By 1897, Japanese missionaries began to convince the leaders of the Japanese fishermen to build a new modernized Japanese hospital, rather than rely on the old make-shift mission hospital. They believed that the fishermen would provide the best source of sustained financing due to their economic success within the canning industry. Long before the introduction of Canada's publically funded Medicare system in the 1950s, early hospitals relied on city funding, subscriptions by members, charitable donations and payment from patients. The Japanese hospital was shaped by an era of dramatic hospital development, scientific medical breakthroughs and professionalization of medical and nursing professions. However, analysis of the founding of the Japanese fishermen's hospital reveals that for smaller hospitals, it was community activism, shaped by important geographical, political, cultural and economic factors, that most determined the unique characteristics of these early local hospitals. This study highlights that alongside the development of medical science and professionalization of health care providers, communities had a profound influence on the development of hospitals in Canada.

In this chapter, I examine the transformation of the Japanese mission hospital into a modern hospital to understand how it became a venture specifically for the Japanese fishermen. I analyse the history of the Japanese fishermen's hospital within the broader context of hospital development in British Columbia to illustrate how small community hospitals, like the Japanese hospital were different from larger hospitals of the same era and were more dependent on local

factors. I begin by explaining how the local geography of the Steveston area led to the establishment of one of the largest salmon canning industries in the world, attracting a large number of workers including Japanese immigrants. I argue that there were important political and economic changes happening in Japan, which not only encouraged Japanese immigration, but also inspired Japanese leaders to envision what they defined as a “modern” hospital in Steveston. I explain how the health of the Japanese fishermen was influenced by the fishing industry, as they were the population most often inflicted with typhoid fever and beriberi. Japanese leaders encouraged the fishermen to offer financial support to build and operate the modern hospital. Influenced by dramatic changes taking place in Japan, leaders amongst the Japanese of Steveston believed the hospital would help to protect the Japanese community against rejectionist rhetoric.

### **The Japanese Fishermen’s Hospital: A Small Local Hospital within the Broader Context of Hospital Development in British Columbia**

The history of the involvement of the Japanese fishermen in the development of the modern hospital in Steveston begins with an understanding of the broader context of hospital development in British Columbia at the time. During the 1860s to 1920s, hospitals in Canada were undergoing a dramatic period of growth. Canadian historians David and Rosemary Gagan argue that it was sometime during the 1890s that hospitals began to change in Canada from charitable institutions for the sick and poor, to modern scientific medical facilities.<sup>1</sup> Middle-class and affluent patients, who previously viewed the hospital as death houses, began to pay for hospital treatment, rather receive care at home. By 1910, hospitals were present in almost every city and town with a sizeable working population in British Columbia. Larger general hospitals tended to be operated by several physicians, board members and managers who were able to

meet the ever-increasing demand for hospital care by offering a tiered system of private, semi-private and public wards. The internal structure of the hospital reflected social structures of the day and helped spur further expansion and development by maximizing both hospital utilization and profit. Gagan and Gagan understand this change as a manifestation of other important social changes including industrialization, immigration, urbanization as well as developments in medical science and public health.<sup>2</sup> Acceptance of germ theory, advancements in laboratory science and new medical technology, like the x-ray, led to improvements in medical diagnosis and treatment.<sup>3</sup>

Along with developments in medical science, the medical profession itself transformed, creating new specializations that began to divide physicians into two groups, the specialist elites and the general practitioners. According to Charles Rosenberg, an American historian of hospital history, this influenced hospitals as the number of speciality hospitals and wards increased.<sup>4</sup> Hospitals refined their services to reflect different types of medicine including surgery, medicine, pathology, ophthalmology, dermatology, venereology, otology, orthopedics and specialities like maternal, child and mental health. Rules in the hospital began to reflect these changes. For example, when a patient arrived with a problem of the eyes, an ophthalmologist would be summoned. The general hospital became the training ground for specialization and eventually certification. Specialization cemented the status of the medical profession and enhanced the image of the hospital as a modern scientific institution.<sup>5</sup>

In addition to medical specialization, the transformation of hospitals was shaped by the professionalization of nursing during the turn of the twentieth century. As hospitals gained legitimacy in Canada, nursing transformed from a group of working-class women who provide rudimentary care, to a middle-class, trained and apprenticed profession. As argued by Kathryn

McPherson in the seminal work, *Bedside Matters: The Transformation of Canadian Nursing 1900-1990* hospital-trained nurses dominated the field of nursing by the end of the nineteenth century.<sup>6</sup> Nursing provided a respectable and therapeutic setting within the hospital and benefited hospitals by offering a large volume of skilled, reliable and relatively inexpensive workers.

Provincial offices of public health also emerged during the turn of the twentieth century. Outbreaks of smallpox in British Columbia led the government to enact legislation that would bring into existence health surveillance, immigrant and school health screening and isolation hospitals. The Public Health Act of 1893 led to the appointment of a Health Board which would collect vital statistics, make sanitary investigations, study disease outbreaks and other conditions influencing peoples work and health. As time passed, divisions within the branch of public health services emerged including epidemiology and laboratories, tuberculosis and venereal disease control, vital statistics and sanitation.<sup>7</sup>

At the same time, the moral reform movement swept across Canada encouraging social purity and the ideals of light, soap and water. Reformers, including clergy, teachers, doctors and social workers, sought to encourage sex hygiene, strict immigration policies, slum clearance and the end of alcoholism, prostitution, and slavery. The movement, placed in the context of nation building, encouraged the dominance of White middle-class Protestant values and beliefs, protecting the capitalist class structure, rather than diminishing social and class inequities related to health.<sup>8</sup>

Through the lens of medical, social and professional advancement, scholars such as Gagan and Gagan have formulated a social history of the typical public general hospital in Canada.<sup>9</sup> These hospitals, like the Vancouver General, were mainly found in cities and were the archetype of the large institutions found today. An examination of the development of smaller

community hospitals in British Columbia during the turn of the twentieth century, however, can further nuance the history of hospitals in Canada. Analysis of historical city directories from 1860 to 1918, reveals there were over 155 homes and hospitals established during this time period alone.<sup>10</sup> As British Columbia grew from a small colony to a sizable province, hospitals were built in almost every community. Though most hospitals provided some level of care for the sick, their size and development was far from uniform.

The first hospitals in British Columbia were established during the early 1860s, called “Royal hospitals” located in Victoria, New Westminster, Barkerville and Nanaimo. The Royal hospitals were larger general public hospitals established with assistance from the dominion/provincial government. During the 1870s, little hospital development was seen anywhere except in Victoria and New Westminster. The establishment of new hospitals was closely tied to population growth, but were often established by different groups, including medical professionals, churches and the province itself. In 1876, for example, St. Joseph’s, a Catholic hospital, opened in Victoria, and the first Provincial Asylum for the Insane was opened in New Westminster. In 1878, the government opened a small Marine hospital in Victoria, which offered care for sick and injured seamen.<sup>11</sup>

As the population and economy of the province grew, so did the development of hospitals. From 1880-1910, hospitals were established in over 48 cities and villages along on the Pacific Coast. Yet, these hospitals were diverse not only in size, but services offered, provider type and number, as well as patients targeted. General public hospitals were the largest and most common type of hospital, but there were also military, ethnic and missionary hospitals as well as speciality hospitals for women, children, the elderly, and the mentally ill which became popular during the early 1900s. By 1910, Vancouver for example, boasted a general hospital, several

private nursing homes, a Chinese hospital, a Maternity Home, a Children's Home, an Old Peoples home, a detention hospital (related to immigration services), an institute for alcoholics, and a city isolation hospital. In response to growing concern about the rise of tuberculosis, sanitariums were built during the 1910s, initially within major cities like Vancouver and Victoria, but later in remote towns like Kamloops, Halcyon Hot Springs, Harrison Hot Springs, St. Leon Hot Springs and Tranquille, British Columbia. The increasing specialization of some hospitals reflected the increasing specificity of medical science and public health. However, there were important differences between large general public hospitals and smaller community hospitals during this time.<sup>12</sup>

Large city hospitals, like Vancouver General Hospital, were designed to provide care to a greater population base, serving many different racial, religious and social groupings.<sup>13</sup> Managed by a board of wealthy businessmen, these hospitals were built to provide differentiated levels of care to maximize accessibility and profits.<sup>14</sup> These large hospitals were also structured to provide physicians and nurses the training ground to improve scientific medical competence and technique. In 1904, during the third year of its operation, the Vancouver General boasted 15 hospital directors and a medical staff of one medical health officer, 12 medical doctors, four consultants, two specialists, one lady superintendent, three head nurses and 22 student nurses.<sup>15</sup> During that year, 851 patients were served for a wide variety of medical and surgical problems. The hospital was under constant construction and with an annual budget of almost \$32,000 was the largest health facility in the province and one of the largest in Canada at the time. The development of hospitals serving much smaller populations, however, often echoed the needs and priorities of local communities, rather than hospital boards or medical professionals.

Smaller community hospitals were often established by local leaders, social activists, health care providers or missionaries. One type of smaller hospital termed *Cottage Hospitals* were established in remote locations of British Columbia from about 1898 to 1919.<sup>16</sup> Many of these hospitals housed seven to ten patients, provided 24-hour nursing care, a small operating room, patient ward and kitchen. A doctor attended when needed, but was often called out for emergencies, travelling to distant locations by boat, horse or dog sled. There was no nursing training provided at most cottage hospitals, as specially trained nurses were hired, whom already had basic nursing education as well as training in Toronto or Montreal by the Victoria Order of Nurses (VON). Women's groups like the Local Council of Women and VON provided financial aid and staff to operate British Columbia's cottage hospitals.<sup>17</sup> Small hospitals were often community strategies, dependent on important local conditions that influenced hospital size, funding, as well as the type of accident, disease, practitioner and patient. Further study of the Japanese hospital, for example, reveals that factors such as local geography, immigration trends, community needs, as well as broader political and economic factors affected the development of the hospital. This is an important insight for nursing because it demonstrates that hospital development has been influenced by local communities, not just by government or health professions. In the sections that follow, I describe how such factors led to the development of the modern Japanese Fishermen's hospital in Steveston, British Columbia during the early 1900s.

### **Steveston: A Place for a Hospital**

Part of the reason a hospital was built in Steveston was because of the geography of the region. The town was located in an isolated corner of Lulu Island at the mouth of the South arm of the Fraser River. Steveston was not officially named until 1890, though British settlers farmed in the area as early as the 1870s. Before that time, the island was inhabited by the Coast Salish

peoples, though the rights to the rivers bounty primarily belonged to the Musqueam peoples. Every summer, thousands of fishermen would arrive in Steveston to take advantage of the millions of juvenile salmon that would make their way down the river to the ocean. As settlers arrived, Lulu Island was divided into farming allotments, and the first dyke was ploughed to protect the land from flooding. By the early 1910s, all of the native villages in the area were lost to colonization.<sup>18</sup>

Only a few years later, fishing and canning were the primary industries supporting Steveston. By 1895, about half a million fish were sold to the canneries, and a total of 499,500 cases of tinned salmon made in the province.<sup>19</sup> Each case contained 48, 1 pound cans of salmon, meaning that nearly 24 million cans were produced that year alone. Salmon were the primary catch of choice, though oysters, mackerel, smelt, whitefish, trout, cod and whales were also fished. Between 1850 and 1917, cannery profits increased from \$26,000 to \$52,000,000 dollars, a 340 time increase over 60 years. During this time period, the Pacific coast was one of the most important sources of canned fish for the world, particularly for Allied countries during the First World War.<sup>20</sup>

From 1890 to 1900, Steveston grew substantially, both in population size as well as the number of businesses. During this period, for example, a post office, seed store, wagon shop, hotel, real estate office, meat market, music store, cookhouse, laundry, livery stables and two Chinese stores were built. In 1890, the Steveston Opera house was built for public gatherings and also served as Steveston's first school. Several churches were established including a Presbyterian, Anglican, Methodist and Catholic Church. Despite these developments, the nearest hospital was a long journey to Vancouver or a several hour ferry ride to New Westminster. Before the Japanese hospital was operational, many residents of Steveston visited the hospitals

located in Vancouver and New Westminster. These hospitals were not as easily accessible as they are today and the Fraser River could be frozen from January to March, making access to hospital care particularly difficult during the winter. A hospital would become even more important in later years, when more women came to live and give birth on the island. This is one of the reasons that eventually a maternity ward was added to the hospital and for many years after almost all babies in Steveston were born at the Japanese Hospital.<sup>21</sup>

Despite rumors that Steveston was a rough frontier town, a correspondent of the Victoria Daily Colonist described the little fishing village as a model fishing town in 1895.<sup>22</sup> The town attracted large numbers of immigrants from around the globe, amidst growing arguments that British Columbia ought to be maintained as a “White Man’s Province.”<sup>23</sup> Non-White workers were an essential source of cheap labour for railway, mining, fishing and canning company owners. Workers were primarily transient, only living in the town during the summer months. Most of the living quarters were bunkhouses and reflected the racial divisions of the time including a Chinese village, Salish village, Hebrew quarter, Japanese village and Italian long cabins. White workers generally lived separately and in the most desirable areas of the town. Even though there was a large population who may have benefited from a general hospital, it was Japanese fishermen who would organize and establish a small hospital on the island. There were important political and economic changes happening in Japan, which encouraged Japanese immigration and inspired Japanese leaders in Canada to envision a modern hospital in Steveston.

### **Japanese Immigration, Modernization and Hospital Development**

The first handful of Japanese immigrants arrived in Steveston in about 1885, though the number increased to 150 by 1888.<sup>24</sup> The first to arrive in British Columbia came from cities in the United States like San Francisco and Seattle, but many entered directly from Japan. The

majority who arrived to work in Steveston came from the small village of Mio-mura in Wakayama prefecture, in Southwestern Japan. Already successful fishermen, these men were able to quickly build a reputation as fierce competitors. Much of what they earned was sent back home to families, encouraging more men to leave for work in Steveston. New arrivals stayed together as *kenjin* or members of the same prefecture and the close connections established made it possible for the fishermen to organize and support the hospital.<sup>25</sup>

A number of factors influenced Japanese citizens' decision to emigrate from Japan to Steveston and later demand a modern hospital. Important political and economic changes that occurred within Japan during the end Tokugawa period (1603-1868), influenced Japan's relations with Western powers, including those with Canada. Historian Midge Ayukawa<sup>26</sup> argues that during the Tokugawa period, Japan restricted trade and relations with foreign powers, particularly those in the West. Japan also maintained a centralized feudal government, ruled by the Tokugawa *shogunate*. The *shogun* was the supreme ruler and head of state and was leader to several distinct social classes. The first class, the *daimyō* were overlords who controlled landholdings in Japan. The next class, the *samurai* were a warrior nobility class, who protected the *daimyo*, but were also administrators and scholars, due to the relative peacefulness of the Tokugawa period. The lower classes included farmers, artisans and merchants. By the mid-1800s living standards increased for peasants due to increased focus on crash crops and individualized farming, rather than cooperative subsistence farming. However, this prosperity came at a cost as the gap between the rural wealthy and poor peasantry widened and fostered civil unrest.<sup>27</sup>

Conflict was further cultivated in 1853 by the arrival of American commodore Matthew Perry and a party of warships. Perry forced the shogun administration to sign the Treaty of Kanagawa, which required Japan to open its ports to trade with the United States. Other Western

powers, such as Britain, France, Holland and Russia followed suit and signed other ‘Unequal treaties’ which allowed foreign powers to dictate tariff rates and trade treaties.<sup>28</sup> As this happened, forces organized to rebel against the shogun and the Boshin civil war returned power to the previous imperial court. A new constitutional monarchy headed by the young Emperor Meiji replaced the feudal system and Japan entered a period of ‘enlightened rule’ termed the Meiji Period.<sup>29</sup>

The Meiji Period (1868-1912) led to enormous changes in Japan’s political, economic and military structures. Unlike China’s government, who countered Western imperial threats by promoting isolation and a period of ‘self-strengthening,’ Japan began a modernization campaign that encouraged Western-style industrialization and militarization. Adopting the phrases *Fukoku Kyōhei* meaning *Rich Country, Strong Military* and *Bunmei Kaika* meaning *Civilization and Enlightenment*, Meiji rulers implemented drastic economic and social measures to achieve their goals.<sup>30</sup> To begin, hundreds of former feudal domains were consolidated and converted into prefectures. The class system was abolished and power held by the former *daimyō* overlords and samurai was relinquished in exchange for massive stipends. Compulsory education was introduced and many Japanese youth were sent abroad for education. Western experts were encouraged to immigrate to Japan to promote Western technologies and education. The government brought in modern machinery, built factories, developed natural resources and constructed a railway system. Western scientific medicine and hospitals were established and Japanese citizens grew a fierce sense of nationalism supporting the modernization campaign.<sup>31</sup>

The Japanese military was reformed in a number of important ways. Firstly, the Japanese military structure was transformed by instituting national conscription in 1873, mandating that every male would serve four years in the military, followed by three years in reserve. This meant

that the previous samurai military was to be replaced by a European-style military. Although many of the samurai joined in this reform, a new military structure was instituted to allow for the mass mobilization of vast armies. The Japanese government utilized French and later German military tactics for land forces and British tactics for the Japanese navy. These military advancements would later solidify Japan's reputation as a world military power.<sup>32</sup>

One of the most important changes that increased emigration was the introduction of land taxes in Japan during the early 1880s. These taxes were levied on the peasantry to fund many of the modernization projects introduced by the Meiji. The tax increases, in conjunction with falling rice prices, caused many to sell their land and seek fortune elsewhere, including Canada.<sup>33</sup>

While changes within Japan encouraged emigration, Japan was able to overturn many of the so-called 'Unequal Treaties' after militarization and defeat of China during the first Sino-Japanese war (1894-1895). Japan's alliance with British forces during the anti-foreign Boxer Rebellion in China, resulted in the first Anglo-Japanese alliance in 1902. The treaty established Britain and Japan as allies in war, guaranteeing war-time assistance in both troops and intelligence. Japan's success in the 1904-1905 Russo-Japanese war convinced the Euro-American world that Japan was an imperial power, one that would now be treated as an equal in political spheres. At a time when both the United States and Canada were attempting to restrict Asian immigration, the Japanese government carefully negotiated 'Gentleman Agreements' that would limit the number of Japanese able to emigrate abroad to a few hundred. Japan's modernization campaign caused world leaders to act more carefully and diplomatically with Japan.<sup>34</sup>

Along with important changes in industry and military, health care was also transformed during the modernization movement. According to scholar Susan Smith, adoption of western

medical science was part of Japan's quest for empire.<sup>35</sup> Before the Meiji period, traditional Japanese medicine called *Kanpō* was the most common form of health care practice. *Kanpō* was derived from Chinese and Korean medicine and included practices such as herbal medicine, acupuncture and moxibustion. Western medicine only became widespread during the late 1800s when Japan began to introduce a medical system that mirrored the health system found in Germany. Medical schools were established and physicians were trained in large hospitals, found in major cities like Tokyo and Nagasaki. Medical licencing was initiated in 1883 and required all candidates to pass an examination, but a standardized medical education was not required until 1916.<sup>36</sup>

Like medicine, professional nursing was introduced in Japan during the early Meiji period. Influenced by the Nightingale training system, British and American nurses were the first to establish nursing schools in Japan. The first nursing training school was opened by missionary Linda Richards in Kyoto in 1886. The development of nursing in Japan, however, was not as important or prevalent during the turn of twentieth century as midwifery. Following Germany's example, doctors established midwifery schools for Japanese women as early as the 1870s. Legislation to guide the practice of midwifery was introduced as early as 1868, while nursing legislation was not passed until 1915.<sup>37</sup>

The establishment of Western-style hospitals also occurred as part of the modernization movement during the early Meiji period. Prior to this era, only a handful of charity Christian hospitals were established by foreign missionaries practicing Western medicine. As Japan approached the Meiji restoration, Japanese military hospitals began to utilize Western medicine and surgery. Soon a large medical school and hospital was founded in Tokyo by the called the *Seiyo Igaku-syo* (Institute of Western Medicine). With financial aid from the government and a

new national health policy in 1874, Western-style hospitals were built in almost every major city. The widespread support of Western medicine and hospitals in Japan during the turn of the twentieth century influenced the push for a modern hospital by Japanese leaders in Steveston.<sup>38</sup>

### **The Fishing Industry and Health**

The fishing industry in Steveston had a great influence on the development of the Japanese fishermen's hospital in Steveston. The industry not only attracted Japanese workers who could pay for a hospital, but also affected the health of the Japanese fishermen more than any other group. Illness was common during the fishing season, which began in July and ended in November. The fishing and canning industries attracted thousands of single men to the area. As a result, they experienced quite different community, family and living structures than they would have in their home countries. During the fishing season, workers lived together in company bunk houses.<sup>39</sup> Many men spent their earnings on brothels, gambling and drinking.<sup>40</sup> They often experienced poor living conditions and when they became ill, few had family to provide food, shelter and health care.

The division of labour of the fishing industry had a significant influence on health. Work was both racialized and gendered with Chinese men, Aboriginal women and Japanese women working different jobs within the canneries, while the Japanese men, Aboriginal men and White men brought in the fish.<sup>41</sup> Those who did the fishing were on the fishing vessels from six in the morning until six in the evening. This meant that many fishermen had little access to fresh food or water. Another problem, particularly for the fishermen was the way that the fishing industry was organized. The fishermen had to have a license to fish and in the early days many had to get an 'attached' license which required the fishermen to rent a boat and equipment from the cannery, in return for their catch. As a result, many fishermen ended the season owing more to

the canneries than they had made. This made it extremely difficult for many of the men to better their living conditions. This prompted Japanese fishing leaders to establish the Fraser River Japanese Fishermen's Benevolent Association in 1900 to obtain independent licenses and become free of the cannery owners.

During the 1890's to early 1900's, there was much concern about the water supply in Steveston. It was well known that water contributed to illness amongst the Japanese fishermen.<sup>42</sup> Many of the men were used to drinking clean water directly from rivers or steams in Japan, and continued to do so when they arrived in Steveston.<sup>43</sup> Unfortunately, this water was contaminated and there was little access to clean water until 1910, when a water and sewage system was installed in the town. Before that time, many residents captured drinking water in rain barrels, with layers of charcoal, sand and gravel to filter the water. Unfortunately, this did little to prevent typhoid that was transmitted through contaminated drinking water. Potable water was delivered daily to some residents, but it was a rare and precious resource prior to the development of the water sanitation system. The lack of clean water led many Japanese fishermen to contract typhoid fever.

### **Typhoid Fever**

Typhoid fever is a serious systemic infection, caused by *Salmonella typhi*, a human-specific bacterium which evolved to persist and be transmitted by its host.<sup>44</sup> The cause of the fever was discovered in the 1880s, and was known to be transferred via food, water and milk contaminated with feces. The disease was characterized by a fever that would last for six to eight weeks, chills, sweating, gastroenteritis and sometimes a rose-spotted rash.<sup>45</sup> Typhoid fever was the most common disease experienced by the Japanese in Steveston, especially for the most

recent arrivals.<sup>46</sup> Chinese workers, on the other hand, were said to rarely acquire the disease because they primarily drank boiled tea.<sup>47</sup>

Typhoid fever was often argued by locals to be caused by the great amounts of fish offal that was dumped into the Fraser River during the canning process. Fish offal consisted of the discarded heads, tails, scales and innards of the chopped fish. In 1892, the amount of offal dumped into the Fraser River was said to be between seven and eight million pounds.<sup>48</sup> In addition to this, it was alleged that at least 200 cases of rotten canned salmon called ‘swell-heads’ were thrown back in to the river.<sup>49</sup> Cannery workers were asked to poke a hole in the tops of the cans so they would sink to the bottom of the river. The dumping of fish waste became such a concern, that in 1892 the British Columbian Fisheries Commission conducted an official inquiry.<sup>50</sup>

To complete the inquiry, 112 witnesses including 50 fisherman and six physicians were questioned at a New Westminster court. Most of the fishermen testified that that the offal was bad for the health of the fish and local workers. Physicians on the other hand, had conflicting views. While only one of the doctors agreed that the offal was the source of typhoid fever, most believed the true culprit was the lack of proper sewage and drainage. Nevertheless, only a few recognized that the offal was dangerous and a cause of dysentery. Dr. Bell Irving, a prominent physician practicing in Vancouver stated:

I do not think it is the offal; if a net was stretched across the Fraser River and all the fish caught in it dumped there, I do not think it would be any worse. This is no opinion got up for the occasion; I have held these views for a long time. I believe typhoid fever there is produced from the same causes as in Vancouver and all other parts of the world, viz.: sewage and cess-pools; they are responsible for nine-tenths of all the typhoid fever the world over. (pg. 388)

As there was no effective medical cure, like antibiotics, available at the time, good nursing care was a vital treatment for men who developed typhoid fever. In 1903, an article in

the American Journal of Nursing reveals an in-depth understanding of typhoid disease progression and treatment.<sup>51</sup> Cases would be managed over a period of weeks with proper nutrition, rest and cleanliness. Nurses would carefully monitor patient temperature, prevent bedsores, treat diarrhea or constipation and disinfect excreta and clothing to prevent spread of the disease. A severe outbreak of typhoid fever amongst the Japanese fishermen encouraged the building of the hospital, particularly because patients could take so long to recover and could potentially continue to spread the illness if proper sanitation was not maintained.

### **Beriberi**

Another significant illness experienced amongst the Japanese fisherman in Steveston was beriberi. The disease manifested mainly as wasting of muscle and fat, difficulty walking, paralysis of the lower legs as well as congestive heart failure. The disease was not well understood at the time and it was believed to stem from a lack of exercise. It was discovered in the early 1900s, however, that beriberi was actually caused by a poor diet. It was not until the late 1920s that beriberi was linked specifically to a lack of thiamine, known as Vitamin B<sub>1</sub>. Thiamine deficiency could be avoided and cured by consuming an adequate amount of vegetables, whole grains and pork. Many Japanese men contracted beriberi, due to a diet of primarily white rice.<sup>52</sup>

The prevalence of disease among Japanese fishermen in Steveston contributed to the utilization of the Japanese Methodist mission as a make-shift hospital. Yet as hospital debts mounted, Japanese missionaries became concerned that the Japanese community in Steveston would lose this vital service. They began to communicate their concerns with the leaders of the Japanese fishermen and Japanese consulate. This was the beginning of the transformation of the Japanese mission hospital into the Japanese fishermen's hospital.

## **From Make-Shift Mission Hospital to Modern Japanese Fisherman's Hospital**

In 1897, a meeting was organized by Japanese Methodist missionaries with over two hundred Japanese fishermen including the leader of the Japanese fishermen's association, and the Japanese consul. The consul, Mr. Tatsugoro Nosse, was asked to make a speech of appeal to the Japanese fishermen to obtain their financial support for the hospital. Mr. Nosse began the speech with a discussion of the expense of the mission hospital. It had cost over \$2000 for the first two years of the mission hospital's operations. Despite the expense, however, he argued that Japanese men who had taken ill in Steveston no longer had to visit hospitals operated by non-Japanese workers. He explained that the Japanese community in Steveston had convenient access to a hospital where their language and customs would be understood. Consul Nosse believed that the hospital would not only provide a convenient place for ill Japanese workers, but the hospital could also be utilized as an important refutation against arguments that these same workers did little to contribute to the local community. Nosse's suggestions were likely influenced by actions taken by Japan as Western nations threatened the sovereignty of Japan during the 1860s. Rather than ignore and reject Western influences during this time, Japan's leaders endeavoured to utilize Western ideas and institutions as a way to defend itself from Western imperialism. Though Japanese leaders supported the uptake of Western ideas, they at the same time endeavoured to clearly define their actions as Japanese.<sup>53</sup> The Japanese hospital would be utilized as an example of how the Japanese community was different from other groups, like Chinese immigrants, who also faced racist rhetoric and exclusionary policy.

To inspire the support of the fishermen, consul Nosse discussed many examples of the increasing movement to restrict Asian immigration, including a \$500 tax on imported Japanese boats. Asian workers were also banned from working in particular sectors, like mining, and

journalists were calling for a boycott of Japanese goods. The Japanese, regardless of birthplace, were barred from voting, and many White British Columbians now supported the repatriation law which would restrict Japanese from becoming naturalized Canadian citizens. Nosse believed that these measures should be countered through action. He stated:

We may not be able to stop the fire of anti-Japanese protest by sticking our hands out, but we can pour water on these anti-Japanese sentiments by showing them our development and business capacity. That is why this hospital is such a crucial symbol of our progress.<sup>54</sup>

Influenced by the modernization movement in Japan, Nosse believed that if the Japanese community in Steveston demonstrated their ability to organize and build ‘modern’ institutions in Canada, they would be protected from rejectionist arguments.

Nosse continued his speech by encouraging the Japanese fishermen to employ a medical staff of Japanese doctors and nurses. Nosse made an appeal to the fishermen to continue their financial support of the hospital, perhaps providing as much as \$2500 for a new hospital, and \$500/year for maintenance. He argued that legal complaint would be sent to Ottawa about the growing boycott of Japanese workers in British Columbia and the hospital would be used as a symbol of pride for the Japanese community in Steveston.<sup>55</sup>

After the large meeting was held, a smaller meeting was held with twenty four members, including Nosse and some of the Japanese missionaries and fishermen.<sup>56</sup> They came to the decision that on payday, 50 cents would be given from each fisherman to the hospital. It was hoped that a Japanese doctor would be hired, if possible. Drug and examination fees would be paid by each patient and a formal application for hospital admissions would be standardized.<sup>57</sup>

Four days later, 500 fishermen gathered at the Imperial Cannery to discuss concerns about the poor fishing catch in recent years. They also hoped to make a firm plan about how money for the operation of the hospital would be raised. Many believed that organizing for a

higher fish price would allow for the continued operation of the hospital. During this year, there were about 5000 fishermen on the Fraser River. Of them, approximately one-third were Japanese. If they allied with White and Aboriginal fishermen, they would be able to demand a better price for their fish. It was decided that the fishermen would strike until better prices were negotiated. On July 8th, a committee of Japanese fishermen leaders including Tomekichi Homma, Iwakichi Shimamura, Teinojo Hayashi, Kamekichi Oda, Kisuke Mikuni and Tadichi Nagao met with the leaders of the White fishermen. The fishermen were able to obtain a two cent raise, which meant there might be more financial support for the hospital.<sup>58</sup>

Consul Nosse continued making plans to pay off the debt of the mission hospital. On July 17, 1897, he received a telegram that Prince Takehito Arisugawa-No-Miya would be visiting Vancouver. Being the first time Japanese royalty were to visit British Columbia, he hoped it might be an opportunity to obtain extra financial support for Japanese populations in the province. A plan was made to welcome the prince. On August 1, 500 boats with Japanese flags waited to greet Prince Arisugawa's ship. Unfortunately, the prince was delayed because of poor weather, but upon hearing of the efforts of the fishermen, contributed \$200 dollars to the Japanese community.<sup>59</sup>

On November 20, 1897 the *Fureza Gawa Ryoshi Dantai* or Fraser River Fishermen's Benevolent Society was informally established. Tomekichi Homma began as acting president, while Iwakichi Shimamura and Kikuske Takahashi would be the society's executives. Several regulations were introduced to continue operations of the current mission hospital. The society's constitution required each member to pay one dollar per year to their respective house boss at the end of the fishing season. The money would allow all members who suffered injury or illness to be treated free of expenses. The fishermen would also be provided burials and gravestones if

they died. The hospital would operate only during the fishing season (July-November) and the benevolent association would pay the salaries of the doctors, nurses and other support staff.<sup>60</sup>

Operations continued at the Japanese mission hospital from 1897-1899, but by the end of 1899, a funding campaign was started by the Japanese Fishermen's Association to obtain the funds to build a new and modern hospital. In total, 55 donations were received, primarily from prosperous Japanese Canadians, reaching a total of \$592.35. Although the benevolent association leaders were somewhat successful in receiving funding for the hospital, the rest of the money would have to be borrowed. Hoping to avoid the prospect of borrowing a large sum, the Japanese Fisherman's Association approached St. Mary's Hospital in New Westminster. They made a proposal that they would pay the hospital a sum of \$500 per year, in return for treating Japanese patients for four months, during the fishing season. The Sisters of St. Mary's refused this request on grounds that they could not possibly take the extra patients. This reply solidified the decision that the Association would proceed with plans to build a new and modern hospital.<sup>61</sup>

## **Summary**

Unlike large public, general hospitals, which have often been studied in the context of medical and professional histories, this study reveals that hospitals were also developed by community activism, shaped by unique geographical, cultural, political and economic conditions. The Japanese mission hospital was initially established because of the need for care of sick Japanese workers within the relatively isolated community of Steveston. However, understanding the political and economic changes that occurred in Japan during the Meiji period, reveals why Japanese workers were drawn to the area and how Japanese leaders were inspired to envision a modern hospital in Steveston. As the debt of the mission hospital mounted and anti-

oriental sentiment heightened, Japanese leaders argued that the establishment of a modern hospital would protect the Japanese community against racist rhetoric and policy.

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- <sup>1</sup> Gagan and Gagan, *For Patients of Moderate Means*, 39.
- <sup>2</sup> Ibid., 13.
- <sup>3</sup> Ibid., 14.
- <sup>4</sup> Rosenberg, *The Care of Strangers*, 169-175.
- <sup>5</sup> Ibid.
- <sup>6</sup> McPherson, *Bedside Matters*.
- <sup>7</sup> Defries, *Development of Public Health in Canada*, 99.
- <sup>8</sup> Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto, ON: University of Toronto Press, 2008)
- <sup>9</sup> Gagan and Gagan, *For Patients of Moderate Means*.
- <sup>10</sup> Vancouver Public Library, "British Columbia City Directories 1860-1955," Vancouver Public Library, accessed November 17, 2014, <http://www.vpl.ca/bccd/index.php>
- <sup>11</sup> Ibid.
- <sup>12</sup> Ibid.
- <sup>13</sup> Donald Luxton, *Vancouver General Hospital: 100 Years of Care and Service* (Vancouver, BC: Vancouver Coastal Health, 2006).
- <sup>14</sup> Gagan and Gagan, *For Patients of Moderate Means*.
- <sup>15</sup> Vancouver General, *Third Annual Report of the Vancouver General Hospital* (Vancouver, 1904).
- <sup>16</sup> Helen Shore, "Cottage Hospitals in British Columbia," *BC Historical News* 33, no. 4 (2000): 14, accessed November 17, 2014,  
[http://www.library.ubc.ca/archives/pdfs/bchf/bchn\\_2000\\_fall.pdf](http://www.library.ubc.ca/archives/pdfs/bchf/bchn_2000_fall.pdf)
- <sup>17</sup> Ibid.
- <sup>18</sup> Bill McNulty, *Steveston: A Community History* (Richmond, British Columbia: The Steveston Community Society, 2011).
- <sup>19</sup> Samuel Wilmot, *British Columbia Fishery Commission Canada Report* (Ottawa, ON: S.E. Dawson, 1892), accessed November 17, 2014, [http://archive.org/details/cihm\\_14378](http://archive.org/details/cihm_14378)
- <sup>20</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 636.
- <sup>21</sup> McNulty, *Steveston*.
- <sup>22</sup> Victoria Daily Colonist, "The Salmon Pack." *Victoria Daily Colonist*, August 18, 1895,  
<http://archive.org/stream/dailycolonist18950818uvic/18950818#page/n4/mode/1up>
- <sup>23</sup> See Roy, *White Man's Province*.
- <sup>24</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 18-19.
- <sup>25</sup> Fukawa and Fukawa, *Spirit of the Nikkei Fleet*, 14-15.
- <sup>26</sup> Michiko Midge Ayukawa, *Hiroshima Immigrants to Canada, 1891-1941* (Vancouver, BC: University of British Columbia Press, 2008).
- <sup>27</sup> Ibid., see ch. 1.
- <sup>28</sup> Auslin, *Negotiating with Imperialism*, 1.
- <sup>29</sup> Ayukawa, *Hiroshima Immigrants to Canada*, ch. 1.
- <sup>30</sup> Louis G. Perez, *History of Japan* (Westport, CT: Greenwood Press, 1998), 100.
- <sup>31</sup> Ayukawa, *Hiroshima Immigrants to Canada*, ch. 1.
- <sup>32</sup> Marius B. Jansen, *The Making of Modern Japan* (Cambridge, MA: Harvard University Press, 2000), ch. 11.
- <sup>33</sup> Ayukawa, *Hiroshima Immigrants to Canada*, 6-7.

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- <sup>34</sup> John Price, *Orienting Canada: Race, Empire and the Transpacific* (Vancouver, BC: University of British Columbia Press, 2011), 18-19.
- <sup>35</sup> Smith, *Japanese American Midwives*, 16.
- <sup>36</sup> Ibid., 16-18.
- <sup>37</sup> Ibid., 18-24.
- <sup>38</sup> Kiyoshi Iwasa, "Hospitals in Japan: History and Present Situation," *Medical Care* 4, no. 4 (1966): 241.; Garrett L. Washington, "St. Luke's Hospitals and the Modernization of Japan, 1874-1928," *Health and History: Journal of the Australian & New Zealand Society for the History of Medicine* 15, no. 2 (2013): 5-28. doi: 10.5401/healthhist.15.2.0005
- <sup>39</sup> Fukawa and Fukawa, *Spirit of the Nikkei Fleet*, 20.
- <sup>40</sup> Thomas Crosby, "From the Fraser Fishing Camps," *Methodist Recorder*, September (1899): 9.
- <sup>41</sup> Renisa Mawani, *Colonial Proximities: Crossracial Encounters and Juridical Truths in British Columbia, 1871-1921* (Vancouver, BC: University of British Columbia Press, 2010), see ch. 2.
- <sup>42</sup> Victoria Daily Colonist, "Typhoid amongst Japanese." *Victoria Daily Colonist*, September 17, 1907, accessed November 17, 2014, <http://archive.org/stream/dailycolonist19070917uvic/19070917#page/n3/mode/1up>
- <sup>43</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 31-32.
- <sup>44</sup> Christopher M. Parry and others, "Typhoid Fever," *The New England Journal of Medicine* 347 (2002): 1770-1782. doi: 10.1056/NEJMra020201
- <sup>45</sup> Ibid.
- <sup>46</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 102, 110.
- <sup>47</sup> Wilmot, *British Columbia Fishery Commission Canada Report*, 221.
- <sup>48</sup> Ibid., 87.
- <sup>49</sup> Ibid., 410-411.
- <sup>50</sup> Ibid.
- <sup>51</sup> Inez C. Lord, "Typhoid Fever," *The American Journal of Nursing* 3, no. 4 (1903): 276, accessed November 17, 2014, <http://jstor.org/stable/3402586>
- <sup>52</sup> Alfred Jay Bollet, *Plagues and Poxes: The Impact of Human History on Epidemic Disease* (New York: Demos Medical Publications, 2004), 141-152.
- <sup>53</sup> Smith, *Japanese American Midwives*, 14.
- <sup>54</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 642.
- <sup>55</sup> Ibid., 643.
- <sup>56</sup> Ibid., 644.
- <sup>57</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 36.
- <sup>58</sup> Ibid., 37.
- <sup>59</sup> Ibid., 40-43.
- <sup>60</sup> Ibid., 44.
- <sup>61</sup> Ibid., 58-61.

# **CHAPTER 4: THE DEVELOPMENT OF THE JAPANESE FISHERMEN'S HOSPITAL: A COMMUNITY PERSPECTIVE, 1900-1919**

In the spring of 1900, the *Sutebusuton Gyosha Jizen Dantai* or Steveston Fisherman's Benevolent Association was officially incorporated in British Columbia. On May 31<sup>st</sup>, 1900, a new constitution was printed and distributed amongst the Japanese fishermen. The constitution outlined the purposes of the society which was primarily to promote the interests of the Japanese fishermen. The constitution also defined how the new hospital would be operated by the Japanese fishermen.<sup>1</sup>

In this chapter, I examine two translated histories of the Japanese fishermen in Steveston to understand how the Japanese fishermen's hospital was built and operated from 1900 to 1919. In contrast to most hospital records of this time period, which are usually written by medical professional or board members, these secondary sources were written by local Japanese Canadians before the internment of World War II.<sup>2</sup> The first book titled 'Encyclopedia of the Japanese in Canada' was published in 1921 by Jinshirô Nakayama who was a well-known journalist in Vancouver at the time.<sup>3</sup> The second book 'The Thirty-Five year history of the Steveston Fishermen's Benevolent Association' was published in 1935 by Teijiro Kobayashi, who was also president of the Japanese Fishermen's society in 1935.<sup>4</sup> Beyond these two secondary histories, very few primary sources exist related to the Japanese hospital.

Within the two publications utilized for this study, the authors include original hospital reports and records of the Japanese Benevolent Association. However, of the records included (spanning from the late 1800s to 1935), the authors concentrate their work mostly on the first

decade of the hospital's existence. Only a few comments are made about the hospital's operation from 1910-1919, excluding any information from 1920 until the beginning of the Japanese internment. These early Japanese-Canadian publications also feature the stories and experiences of the first generations of Japanese in Canada. From the perspective of Nakayama and Kobayashi, the books were created to provide a written history of the Japanese in Canada to offer later generations the chance to understand both the hardships and victories of the first Japanese communities in Canada. Unlike most histories of hospitals in Canada and abroad, utilizing these secondary texts has provided a unique opportunity to analyse the development of the Japanese hospital from the perspective of Japanese community leaders.

Understanding the development of hospitals from a community perspective offers new insights about health service development during the turn of the twentieth century, particularly in the context of colonialism. In the field of nursing history scholarship, much of what is written about this context and time period focusses on the role of nurses in developing Western medicine and hospitals in non-Western countries.<sup>5</sup> Scholars often discuss the challenges and opportunities experienced by nurses who brought nursing to various non-Western countries, as well as examine the unique contributions that nurses made to the establishment of professional nursing around the globe.

Scholar Elizabeth Simon for instance, discusses the rise of modern nursing in India from the mid-1800s to 1947.<sup>6</sup> Due to Britain's influence, professional nursing training was introduced to India through Florence Nightingale's training system. However, nursing in India was often restricted to practice by Christians and Anglo-Indians because of the constraints for providing "hands-on" care by Hindus and Muslims due to caste and purdah systems. As a result, many of India's largest and most influential hospitals began as pioneer Christian missions. Interestingly,

the Japanese hospital in Steveston began in much the same way, through the influence of Christian missionaries. Yet, rather than Western missionaries utilizing and transferring Western ideas about health and hospitals to Asian groups, the idea for the modern hospital actually originated from Japanese community leaders themselves.

Other scholars who have studied the development of nursing and healthcare in the context of colonialism during the twentieth century have argued that nurses acted as ‘agents of the empire’ and had a significant role in furthering the goals of Western imperialism and colonialism.<sup>7</sup> Such scholars have tended to examine relations of domination and subordination between White and Non-White groups. Katrin Schultheiss for example, argues that nursing reformers attempted to reinforce European control over foreign bodies and cultures by instilling European ideals of gender, race, and civility.<sup>8</sup> She argues that this history is not one of progress, but rather of good intentions, reform and ambition mixed with ethnocentrism, arrogance, and thoughtless imperialism. The history of the Japanese hospital complicates this argument by demonstrating that in some cases, Western institutions, such as the hospital, have been utilized by some non-Western groups as a means to combat racial discrimination in colonial contexts. This is an important finding for nursing because it demonstrates that hospitals can act as more than spaces to offer care and medicine to the sick, hospitals can be utilized by communities to confront broader societal inequities.

The publications written about the first Japanese communities in British Columbia can also tell the story of hospital development with community as protagonist, rather than nurse. Utilizing this perspective is useful as it can reveal that hospitals could be viewed as more than a training ground for nurses or safe refuge for marginalized groups. Rather, the history of the hospital can also reveal broader economic, political and racial relations that shaped the

development of health care in Canada. An examination of the history of the Japanese hospital reveals that the hospital played an important role in the Japanese community's struggle for racial and economic equality.

### **The Development of the Japanese Hospital in the context of Racial Discrimination**

During the late 1800s to early 1900s, racial discrimination became an increasingly common experience for Japanese populations in Canada. In Steveston, economic competition heightened racial tensions between White and Asian groups, particularly for fishermen in the canning industry. Though generally Japanese workers in British Columbia were viewed and often treated more favourably than Chinese workers, Japanese leaders grew concerned when politicians and newspaper journalist began to propose that Japanese immigration be restricted.<sup>9</sup>

Patricia Roy's study of political attitudes towards Japanese and Chinese immigration in British Columbia (1858-1914) reveals that Asian groups were often criticized for their alleged inability to assimilate to Western ways.<sup>10</sup> As Japanese fishermen became serious competitors in the attainment of gill net licenses, they were accused by the White labour union of creating unfair competition and driving down fishing prices. Anti-Asian groups further argued that the wealth obtained by 'Asian sojourners' was sent abroad, rather than spent locally. They claimed that the Japanese workers were not worthy of naturalization and citizenship in Canada because they made no contribution to Canadian society. As the Japanese population grew from about 1000 in 1896 to 4544 in 1901, calls for the restriction of immigration and anti-Asian sentiment intensified.

The writings of Nakayama<sup>11</sup> and Kobayashi<sup>12</sup> reveal that Steveston's Japanese community's foremost concern was protecting its workers from racism and economic ruin. Their accounts of what happened during this time period reveal that the Japanese hospital played an

important role in the struggle for racial and economic equality. Rather than be viewed only as what other historians often characterize as ‘A factory for the production of health’<sup>13</sup> or medicine’s ‘Professional workshop,’<sup>14</sup> the Japanese hospital was viewed as an important tool in the struggle for racial equality. The history of the hospital itself is woven into stories about the fate and fortunes of the Japanese fishermen. Viewing the hospital in this way can broaden nursing scholars’ views of the hospital as only health institutions or places to care for the sick. Hospitals can also be utilized to confront social inequities, shaped by broader influences like race relations.

### **Building the Modern Japanese Hospital through Labour Activism**

As soon as the *Dantai* committed to build the new modern hospital, much was to be done if the hospital was going to meet the high expectations of the Japanese leaders. According to Nakayama, the Japanese Steveston community were different than those in other regions of British Columbia. In many communities, fishermen simply rented their supplies and boats from the canneries, in return for their catch. In Steveston, however, the Japanese fishermen organized so that they could become independent from the cannery owners and demand better prices for their catch. This alone was not enough for the Japanese community to protect their people from racial discrimination and exclusionary arguments. The *Dantai* felt that they must also build schools and hospitals to allow “the political leaders of Canada to see a new phase of development of the Japanese....a symbol of the pride of the Japanese people.”<sup>15</sup> From the perspective of Japanese leaders, developing these “modern” institutions would help quell arguments that Japanese sojourners did little to contribute to the local community.

According to Nakayama, even with a written commitment to pay for the building of a modern hospital, leaders of the *Dantai* questioned whether subscriptions from the fishermen

would also cover the hospital's yearly operating costs. In response to these concerns, the *Dantai* decided that the only way to pay for the hospital was through labour activism. This activism would focus on yearly negotiations for better fish prices from the canneries. During the first several years that the Japanese had been fishing in Steveston, leaders of the *Dantai* learned that every four years a poor fishing season would be followed by a better one. During poor fishing seasons, the canneries would offer up to 25 cents a fish, while in the good years, they would offer only 15 cents per fish. The *Dantai* was determined to obtain a much more profitable and stable price to fund their ambitions in Steveston.<sup>16</sup>

The Japanese fishermen were met with strong opposition from White fishermen. They had already responded to the differences in fish prices by organizing unions and demanded at least 25 cents per fish. The White fishermen fiercely protested against the issuing of the largest number of licenses to Japanese fishermen. White labourers formed a union and organized the first strike as early as 1893, working towards higher fish prices and ending Japanese competition. By 1900, White fishing labour unions were formed in Vancouver and New Westminster. At first, the Vancouver union attempted to include the Japanese fishermen, but ultimately they were barred from joining. The Japanese responded by forming their own labour organization. Being a poorer fishing season, the canneries offered 20 cents per fish, for up to 600 fish caught. On July 22, 1900 the Japanese fishermen accepted this agreement and began to fish. This decision solidified the economic rivalry between the Japanese and White fishermen.<sup>17</sup>

The price negotiation obtained by the Japanese fishermen was supported both by the canneries and the Japanese Imperial government. The Japanese fishermen continued to fish, but not without loss. Several boats were stolen and nets were cut. Japanese leaders encouraged workers to carefully document all cases of vandalism. Despite the increased animosity and

relatively poor economic situation, Nakayama argues that the Japanese fishermen continued to operate the mission hospital, hygiene division and police force, despite one of the most difficult years. Indeed, the Japanese community envisioned a hospital that would eventually be much larger and more sophisticated than other hospitals in British Columbia in similarly sized communities.<sup>18</sup>

Through the spring and summer of 1900, the *Dantai* continued plans to build the new hospital. However, as Kobayashi observes, “Building the hospital was beyond [the *Dantai*’s capability]...and employing doctors with one thousand dollar salaries was beyond its capabilities as well...the pioneers pushed their capability to the limit, then pushed beyond the limit.”<sup>19</sup> The hospital they envisioned was indeed large considering that Steveston was a relatively small community of 300-400 people and the number of beds was close to 30. Building such a relatively large and modern hospital was very difficult for the Japanese pioneers to achieve. Supporting a hospital this size would be a challenge for any group during this time period, particularly without funding support from government, church or other large organization. The much larger Vancouver General Hospital (VGH) (with approximately 180 beds in 1906, serving a population of a little over 30,000), for example, would obtain tens of thousands of dollars of funding from the city of Vancouver, patient fees and yearly subscriptions from affluent members of the city. Also, VGH had a local Women’s Auxiliary that supplied them with goods, furniture and linens.<sup>20</sup> The Japanese pioneers would be challenged to find and sustain the financial means to operate such an institution, even on a much smaller scale. Moreover, records indicate that the Japanese went ahead with their plans, even when at times it appears they may have not had the means or knowledge to proceed.

Records utilized by Kobayashi indicate that on June 6, 1900 an attempt was made to buy lumber for the hospital, but the order was rejected due to a lack of information regarding the building plans. To remedy the situation, two Japanese board members travelled to New Westminster to have plans produced for the building. A new lumber order was sent to the Royal City Mill with a cost of \$1,100. To pay for the materials, a group of fishermen from Wakayama prefecture people donated \$700, while workers at the English Cannery paid \$400. By June 11, 1900 land had been purchased with a deposit of \$150. The Japanese hospital site was inspected and surveyed on a few days later. Lumber and other building materials arrived shortly after and 150 local fishermen came to help unload the supplies.<sup>21</sup>

Trained medical staff were part of the *Dantai*'s vision for a modern hospital. Plans were made to employ doctors and nurses trained in Western medicine, as well as Japanese workers to help with cooking and cleaning. A notary public was hired to create contracts for the oncoming medical staff. The *Dantai* also arranged for furniture and supplies to be purchased including chairs, tables, medicine and other provisions.<sup>22</sup>

As mentioned in Chapter 1, the *Dantai* first made an attempt to hire Japanese physician Dr. Soga from San Francisco. No records exist to confirm Dr. Soga's identity or level of training. However, Kobayashi reveals that Dr. Soga was taken to trial by a White doctor because of "a violation of medical law."<sup>23</sup> Although Kobayashi describes the trial as "ending peacefully," the aftermath was that for many years the Japanese *Dantai* seems to have exclusively hired White physicians.<sup>24</sup>

After the incident involving Dr. Soga, several applications were received for the position of physician at the Japanese hospital. The society soon employed the services of William Brenton Burnett, who had just relocated to practice medicine in Vancouver, British Columbia.

He was originally from Sussex, New Brunswick, where he was first educated as a teacher at Acadia University in 1891. He later taught school in Alberta and moved to Vancouver to become assistant principle of the Central School at Pender and Cambie Street. Burnett left Vancouver for Montreal to study medicine in 1895. In 1899, he became a member of the College of Physicians and Surgeons of New Brunswick and returned to Vancouver to start a medical practice. He began his career working at both the Japanese hospital and as a physician at an office in downtown Vancouver.<sup>25</sup>

Dr. Burnett worked at the Japanese Hospital in Steveston for only one year. During that time he provided care for mainly Japanese men sick with typhoid fever and beriberi. Dr. Burnett took part in building and operating the hospital during its first year of service. Each morning at 6:00AM, a team of horses would arrive from a livery stable on Burrard and Pender and he would drive the team to Steveston, arriving at 8:00AM. He would see patients until 11:00AM and make his way back to Vancouver to continue seeing patients at his downtown office.<sup>26</sup>

The contract signed by Dr. Burnett stated that he would act as physician and surgeon for the hospital from July 1, 1900 to November 13, 1900.<sup>27</sup> During that time he would be responsible for the supervision and management of the hospital. Burnett would make one visit per day, and attend to all subscribers of the hospital. In return, he would receive \$160 per month or a total \$800 for the entire season. Dr. Burnett could also receive additional fees for venereal and obstetric cases, which was very common for physicians during the early 1900s.<sup>28</sup> This was likely a fair salary for a new doctor, given that the average income of doctors in Canada from 1900-1930 was 2000-6600 dollars.<sup>29</sup>

Though the *Dantai* was able to hire Dr. Burnett for the first year of operation, it became evident that the *Dantai* spent far beyond what they could afford. Earlier that year, a budget that

was created for the hospital revealed that the board members intended to spend only \$300, rather than \$800 on physician wages.<sup>30</sup> Costs further increased as two trained nurses were hired, Mrs. Gorne and Miss Edith Alcon who graduated from Montreal General in 1899.<sup>31</sup> Miss Alcon later married Dr. Burnett in 1903 after working at the Japanese hospital together.<sup>32</sup>

As hospital construction continued, the *Dantai* was determined to continue the fight against racial discrimination. One important goal was to incorporate the Japanese Fishermen's Benevolent Society, and this was accomplished on June 28, 1900. Kobayashi argued that this step would give the association status equal to the White labour groups. The *Dantai* made special arrangements to publicize the construction of the hospital in local media. The fishing season would begin in just a few weeks, and the new hospital would be officially opened by the end of July.<sup>33</sup>

On July 23, 1900, a small ceremony took place to celebrate the launch of the new hospital. Patients were moved from the old mission hospital into the new modern building. The new hospital was a large wooden building divided into 13 different rooms. There was a large stairway leading to the hospital entrance, over which a large sign with the words 'Japanese Hospital' was posted. Once patients entered the building, they found a pharmacy counter to the right and an examination room to the left. A little further ahead was another door that led to three rooms for patients with a total bed capacity of thirty. The southern portion of the building was divided into two additional patient rooms, another room for surgery and a storage room for medical supplies and linens. At the very end of the hall on the left, there were three rooms for nurses' quarters, on the right was the washroom and cafeteria. A laundry area was set up in the garden. The building housed a total of three bathrooms.<sup>34</sup>

With all of these modern amenities the Japanese hospital was larger than many smaller community hospitals elsewhere in British Columbia. For example, many of the hospitals established in Northern British Columbia accommodated generally 10 or less beds, depending on the size of the population served.<sup>35</sup> One of the largest hospitals established in the North at this time was the Port Simpson hospital, built in 1892, and it initially housed 11 beds. The Port Simpson hospital was built with funding from the Hudson Bay Company and the Provincial government. The hospital was erected in a region similar to Steveston, in that it was positioned at the mouth of the Skeena River, also near several cannery operations. Despite its small size, the Port Simpson hospital had one of British Columbia's first nursing-training programs and residence, paid for by the Women's Missionary Society of the Methodist church.<sup>36</sup>

The Japanese hospital provided no formal nursing training, but instead employed Japanese community members as often as possible. Unlike other hospitals of the time, for example, the hospital attracted a Japanese medical student, Kenrei Ozeki.<sup>37</sup> He was given employment as one of the nurses at the hospital. In addition, Japanese midwives were often utilized for mothers giving birth<sup>38</sup> and Japanese auxiliary staff were hired including a cook, cleaner and launderer.<sup>39</sup> For the Dantai, it was important to have staff trained in Western medicine, but to also utilize as many Japanese workers as possible to demonstrate the Japanese contribution to the community.<sup>40</sup>

### **Increasing Economic and Racial Conflict Threatens Hospital's Demise**

After the modern Japanese hospital was built, economic conflict between the White and Japanese fishermen further intensified. At the end of July in 1900, several policemen and soldiers were dispatched to Steveston in an attempt to keep the peace. Acts of violence and vandalism were also perpetrated by White and Japanese fishermen. The increasing violence and poor

fishing season influenced the financial standing of the Japanese hospital. The fishing strike that took place earlier in the season made it difficult to pay the mounting hospital costs. The Japanese executive still owed money to the pharmacy for medications and salaries were due as well to Dr. Burnett and nurses Alcon and Gorne. The situation became so desperate that the association took action by circulating a request for aid and support across British Columbia, including the provincial newspaper.<sup>41</sup>

The request for aid that was submitted to the newspaper reveals that the hospital costs reached close to \$7700, less \$4000 paid by the Japanese fishermen, leaving a debt of \$3700. The *Dantai* argued that the general public should consider helping to pay the debt because the hospital was a general hospital, open to any member of the public, regardless of race. The hospital board described the opening of the hospital, and how over 500 patients had utilized the hospital services. It was hoped that the request for aid would help the *Dantai* acquire financial support from sources outside the Japanese community. However, the *Dantai* also sought financial support from local Japanese communities in Vancouver, Seattle and Victoria, raising \$2000. Despite efforts to obtain funding from the wider non-Japanese community, it was primarily the Japanese communities in the surrounding areas that saved the hospital from an early demise. This finding indicates that despite the Japanese community's efforts to establish a "modern" hospital, equal to that of other hospitals found in the province, it was not supported more widely by White British Columbian's.<sup>42</sup>

A record of the hospital operations documented by Kobayashi indicates that the Japanese hospital had been well-used during the first year of operations. The hospital was described as providing the Japanese fishermen who paid a subscription with free medical examination, drugs and hospital care. More than 30 patients visited the hospital each day. Hospital beds were almost

always filled, with up to 36 patients admitted at one time. A few white and Aboriginal workers were admitted, but they were required to pay a fee for access to the hospital's services.<sup>43</sup>

Statistics taken during the first year of operation alone reveals that the total number of patients who visited the hospital was actually 750, with 182 hospitalized and 568 walk-in cases. Of these patients, only 27 patients died during the season, not including the number of men who drowned, which brought the totally mortality count to 45. The average age of those who died was 35 or 27 when drowning cases were included. Most of the men were sick with typhoid fever and beriberi. Of the patients who became ill, many were new arrivals from overseas. The board argued that the hospital had helped to keep the death rate low among the 3,419 members of the Japanese Benevolent Association. Despite a difficult and challenging first year, the Japanese hospital had become an important community service for the Japanese population in Steveston. Yet clearly the economic and racial conflict kept the operation primarily a Japanese service.<sup>44</sup>

After the poor fishing season in 1900, the Japanese fishermen eagerly awaited the prospective catch of 1901. A general meeting was held at the hospital in April to organize for the upcoming year. It was decided at the meeting that all board members would lend five dollars to finance the opening of the hospital on June 1st. General members were asked to pay two dollars per boat by the 15<sup>th</sup> of June. The board would also be required to advertise for another physician for the fishing season. A suggestion was made that another branch be established along the North Arm of the Fraser River, with Kenjiro Nogeki as branch chief. The doctor at Steveston would now be required to visit Steveston and this new branch daily.<sup>45</sup>

By May 12, 1901, it was decided that Dr. R. R. Robinson<sup>46</sup> would be hired for six months and paid \$1,000 or \$167 per month. He would be responsible for daily visits as well as attendance at all urgent cases without extra fees. He would also not be allowed to charge fees for

venereal diseases, nor for any births attended at the hospital. The hospital would charge extra fees to women who gave birth attended at home and utilized the services of the hospital's doctor. The board decided to hire two White and two Japanese nurses, though the level of training of these nurses is unknown. Japanese support staff were also hired, including Yasuonosuke Sugaya who would be assistant nurse and Shichizo Hori who was hired as interpreter. Mr. Kinsuke Mikuni was employed as the hospital's new director.<sup>47</sup>

To ensure the hospital could maintain operations, the most important matter of business for the Japanese fishermen was the negotiation of fish prices with the canneries. It was agreed that the fishermen would receive 12.5 cents per fish, until August fourth, then the price was lowered to 10 cents. After consideration, the canneries decided to offer 12.5 cents per fish from July 1st to 27<sup>th</sup>, then 10 cents thereafter, with up to 200 fish per boat per day. The *Dantai* accepted the proposal, but warned that they would expect the same price as the White fishermen. Later the *Dantai* learned that the White fishermen had proposed 15 cents per fish, and attempted to prevent any new Japanese labourers from obtaining fishing licences. The White fishermen complained to government officials that Japanese fishermen were entering Canada from the United States only for the fishing season, then travelling back after the season ended. Meetings were held by White labour groups at city hall to strengthen anti-Japanese sentiment, but the Japanese community in Steveston remained steadfast in their determination to start the season in July. The *Dantai* held a meeting July 2<sup>nd</sup> to organize for the first day of fishing. The Japanese fishermen had obtained 1450 fishing licenses, and wanted to ensure the safety and protection of the Japanese fishing fleet. With the full support of canneries, the Japanese prepared to start fishing the following week.<sup>48</sup>

On July 7<sup>th</sup>, the Japanese fishermen gathered at the wharf, made three cheers and pledged to act fairly and justly as they commenced the fishing season. In response to the gathering, White fishermen used a number of patrol boats to surround the Japanese boats, beating the Japanese men with clubs and cutting their fishing nets. The Japanese fishermen contacted the police, and began to organize their own escort boats. On the night of July 10, gunshots were heard and a Japanese fishing boat was found wrecked on English Bay with a pool of blood on the ship. Six White men were taken to the police station for questioning.<sup>49</sup>

The following morning, it was found that seven Japanese fishermen were missing. Rumours mounted about the men being killed by the White fishermen, but soon it was reported that they had been taken prisoner on Bowen Island, an island just West of Horseshoe Bay. On July 11<sup>th</sup>, a tug boat rescued seven men waving frantically for help from a rock on the island. The men reported that they had left the Imperial Cannery the day before to fish near Point Grey, but were surrounded by White patrol boats and threatened with clubs and pistols. The White men cut the Japanese fishermen's nets and dragged their boats to the island, taking away the sails, oars and rudders. The White fishermen told the Japanese fishermen that if they dared to fish again, without waiting for the White fishermen to start the season, they would be killed. Six of the White fishermen were taken to trial, yet only one of the men received charges. It was later found that two Japanese men disappeared altogether and were presumed murdered by the White fishermen. These events solidified the resolve of the Japanese fishermen to continue fishing, despite the threats made by the White fishermen. The conflict however, led many of the fishermen to begin to doubt the capability of the *Dantai* executive to support the Japanese fishermen.<sup>50</sup>

In 1902, questions began to arise about the necessity of the Japanese Fishermen's Benevolent Association. On May 11, 1902 the first annual general meeting was held at the Japanese hospital with 50 members in attendance. Before the meeting began, a few members argued that the society was unnecessary and should be dissolved because of the great expense to the Japanese fishermen. A vote was held and with 46 votes in-favour. It was decided that the *Dantai* would continue and another meeting would be held in June to discuss the organization's operations.<sup>51</sup>

On June 1, 1902, a second general meeting was held and arguments were again made about whether the society should continue operations. Surprisingly, the group of fishermen questioning the continuation of the *Dantai* fully supported the continuation of the hospital, but believed that the society itself was an unnecessary financial burden. In response to these arguments, another vote was held, and 80 percent of the fishermen agreed that the *Dantai* continue operations.<sup>52</sup>

Despite the results of the second vote, at the third meeting on June 8<sup>th</sup>, more arguments were made from those who opposed the continuation of the *Dantai*. Members made the assertion that executives were not working hard enough to improve membership and ensure that expenditures were reasonable. This discussion ended with the resignation of the previous year's executives and an election of a new group that would represent each major housing area in the Japanese community. Finally at the fourth general meeting, the *Dantai* developed a budget for the coming fishing season and it was decided that every effort would be made to minimize unnecessary expenses. The *Dantai* decided that the organization would continue to oversee developments at Steveston and the North Arm branch and the hospital would continue operations for the upcoming fishing season.<sup>53</sup>

## The Japanese Fishermen's Hospital as Leverage for Pay Negotiation

At the end of June in 1902, the Japanese Fishermen's Association began another year of negotiation with the fishing canneries. Plans for the hospital also began and it was decided that physician R. F. Greer, as well as Japanese physician Dr. Meinosuke Ishiwara would be hired at the hospital. Dr. Ishiwara was educated in Tokyo and was one of the first Japanese doctors to practice on Powell Street.<sup>54</sup> By July 23<sup>rd</sup>, the board decided that Dr. Greer required much more salary than expected, so Dr. Williams was hired instead. Mr. Goro Kaburagi, Japanese Methodist minister at Vancouver volunteered his time to assist at the hospital as a volunteer nurse and interpreter. Kozo Shimotakahara, who would later also work as a physician in Vancouver, would work as cook at the hospital.<sup>55</sup>

As the beginning of the fishing season drew near, the Japanese fishermen's association once again faced attempts at regulation by the White fishing leaders. They proposed to limit the licences allowed for the Japanese fishermen. The *Dantai* did not worry about these rumours because leaders felt that the canneries relied on the Japanese more than any other group. The *Dantai* did, however, resolve to strike until the canneries paid at least 15 cents per fish. Unfortunately, not all of the Japanese fishermen agreed with this decision. Some believed that fishing should commence even if the prices were low, because they would rather earn some income this season, rather than forego most of the season like last year. Another group within the Japanese fishermen believed that they should hold out for higher fish prices. After some negotiation, it was decided that the Japanese fishermen would begin working early at a lower price, but only if the canneries agreed to pay the \$2300 debt of the hospital. Thus, the Japanese Fishermen's Association utilized the hospital itself as leverage for better pay from the canneries.<sup>56</sup>

The canneries countered the offer made by the *Dantai*, with a contribution of only \$500 dollars for the hospital if fishing commenced immediately. The Japanese fishermen turned down this offer and arguments about the fish price led the North Arm Branch to separate from the *Dantai*. The Steveston fishermen decided to begin fishing, though the fishing season for 1902 and 1903 were viewed as poor fishing years. According to Kobayashi, the *Dantai* executive struggled to maintain all they had built, but were determined to obtain rights equal to the White fishermen, “to become the best Japanese organization in the Pacific Coast.”<sup>57</sup> The hospital was still a fundamental part of the *Dantai*’s plans and would continue as an important institution for the community in Steveston.<sup>58</sup>

### **The Later Years of the Japanese Hospital**

Records from Nakayama and Kobayashi indicate that ongoing discrimination would continue to threaten the fate of the Japanese hospital. Unfortunately, little is known about the hospital after the initial few years until the Japanese Internment of World War II. The hospital appears to have been utilized primarily during the fishing season (which generally took place from July to November), but was sometimes utilized as a school and meeting place during the rest of the year. During the first ten years, there were anywhere from 20 to 180 in-patients per year (see Table 1). The hospital also served the needs of hundreds of out-patients, who likely required medical treatment for minor ailments. Thus, the hospital also functioned as clinic and dispensary, in addition to offering in-patient and surgical services, which were not unusual functions for hospitals during this time period.<sup>59</sup>

Table 1: Hospital Operations for the First Ten Years

<b>Year</b>	<b>1901</b>	<b>1902</b>	<b>1903</b>	<b>1904</b>	<b>1905</b>	<b>1906</b>	<b>1907</b>	<b>1908</b>	<b>1909</b>	<b>1910</b>
<b>Members</b>	3419	3471	1160	1860	883	1252	584	1018	984	1569
<b>Operation From - To</b>	Jul Nov	Jun Nov	Aug Nov	Jul Nov	Jul Nov	Jul Nov	Jul Oct	Jul Nov	Jul Nov	Jul Nov
<b>Hospitalized Patients</b>	180	180	21	66	31	64	18	46	26	67
<b>Outpatient First time Return</b>	575	840	372 497	595 710	263 604	646 262	474	561	315 281	487 241
<b>Death Rate</b>	45	17	2	8	4	5	0	3	1	17

Of the records remaining, it seems that until 1906 the *Dantai* continued to struggle to pay the hospital's operating costs, particularly during years in which the fishing outcome was poor. In 1904, the *Dantai* had only \$457 credit to start the season, while the running cost would likely come close to \$5000. At the general meeting, some of the fishermen suggested that the hospital might have to be closed because of several years of poor earnings. Nevertheless advocates for the hospital argued, "Sickness may come at any time, and if we cannot open the hospital because of lack of money, how can the Japanese keep their pride?"<sup>60</sup> Thus the continued operation of the hospital clearly reflected both the economic well-being and social status of the Japanese community in British Columbia. According to Kobayashi, this strengthened the resolve of the *Dantai* to continue to operate the hospital despite any financial difficulties that might arise.<sup>61</sup>

The poor season in 1904 was somewhat compensated by the canning of dog salmon that was begun exclusively by the Japanese, who were able to sell the product in Japan. However, the profit from this new endeavour was still not enough to pay for the hospital's debts. By August,

the subscription fee was increased to \$1.50 by the *Dantai* with the idea that most of the debt would then be paid. Yet the remainder of the debt would have to be borrowed, using the hospital building as collateral. The *Dantai* was able to raise an additional \$150 from charity efforts. By 1905, the number of fishermen increased by 400 and Japan won a decisive victory against Russia during the Russo-Japanese war in 1905. In honor of the battle, the canneries donated \$500 to the *Dantai*, and a further \$538 was donated by the Japanese fishing bosses. This was followed by an excellent fishing year in 1906, which allowed the *Dantai* to pay off the debt of the hospital, allowing the association to finally own all of its own land and buildings.<sup>62</sup>

In 1907, a large influx of Japanese arrived in British Columbia from Hawaii, all of whom could not be accommodated in Vancouver, so it was suggested that the Japanese community in Steveston assist a portion of the newcomers. The *Dantai* agreed that they would help the newcomers if they would donate 50 cents per person to the association. The newcomers would in return be allowed to access the hospital for free examination and drugs, including the cost of hospitalization and funeral service if needed. The newcomers, however, could spend no longer than one month in hospital, and would be refused entry first if the hospital was full.<sup>63</sup>

In the fall of 1907, White labour groups gathered in Vancouver to protest a large influx of Asian workers. They began what would later be known as the “Vancouver Riot of 1907” in Chinatown and in the Japanese quarter on Powell Street. The mob threw bricks and stones at Chinese and Japanese properties, leaving some with minor injuries and costing many hundreds of dollars of property damage.<sup>64</sup> According to Kobayashi, the *Dantai* decided to change the name of the association in 1908 in response to these attacks. The *Dantai* hoped that the name change would encourage the wider community to support the necessary legislation that would make it possible for the Japanese fishermen to become naturalized British subjects. Kobayashi explains,

“Those who are naturalized to Great Britain should not specifically call themselves Japanese.”

The *Dantai* changed the official society name from, “The Fraser River Japanese Fishermen’s Benevolent Association” to “The Steveston Fishermen’s Benevolent Association.” The *Dantai* clearly supported the view that the Japanese be considered Canadian and continued to attempt to close the gap between Asian and White identities.<sup>65</sup>

As the years continued, the *Dantai* increased user subscriptions to expand upon the hospital’s services. As more and more women arrived in Steveston, maternity services became an important service and commodity. In 1909, the *Dantai* opened the hospital for the fishing season and hired “a Caucasian physician, nurses and cook.”<sup>66</sup> The hospital board planned to add a new pharmacy, examination room and operation room by the following year. Subscribers were still treated at the hospital for free, but non-members were charged \$5 weekly. Subscribers also were provided a funeral at \$25, plus \$5 relief for the widow/family. The *Dantai* also decided to hire a full-time hospital director to ensure that an administrator was present at all times on site and available to lead operations.<sup>67</sup>

By 1910, the *Dantai* proposed to operate the hospital for an entire year, rather than only for the fishing season. They employed trained registered nurses as well as a midwife. Membership fees were increased to \$5 per adult, \$2.50 per child. The hospital charged \$7.50 for delivery of babies with the use of the hospital’s midwife. The fishing season had been prosperous, allowing for some improvements to be made in the years that followed. Nevertheless, the *Dantai* was not free from the financial burden of operating the hospital.<sup>68</sup>

In 1911, the *Dantai* reported that the hospital expenses utilized nearly 70% of the total budget. Fees received from White patients generated a great deal of revenue, but expenses still

outpaced income. Before long, however, the *Dantai* was able to pay the almost \$800 debt due to the generosity of the villager donations.<sup>69</sup>

After the first ten years of operations, the hospital was updated and expanded again. In 1913, the *Dantai* arranged to build a new operating room with several pieces of new equipment to allow for more complicated surgical procedures. Previously, the *Dantai* had paid to send these patients to Vancouver. The operation room was complete by 1914. By 1916, the hospital was open every day from 10:00AM to noon and again from 4:00PM to 5:00PM, except for Sunday. The hospital had a doctor and nurse and were submitting regular reports to the hospital director. The number of births had increased significantly during the latter half of the 1910s due to the increasing number of Japanese women immigrating to Canada. A second delivery room was needed and funding efforts began in 1917. The new delivery room was completed in May of 1917. The hospital director also began to incorporate public health measures to promote hygiene in Japanese homes, schools and public spaces, likely with influence from new public health services in the province.<sup>70</sup> The introduction of public health services demonstrates perhaps that the *Dantai* continued to strive to meet and maintain existing Western approaches and standards.

In 1919, the hospital board had successfully hired a Japanese physician, Dr. Kusaka and a Japanese nurse through contacts in Japan.<sup>71</sup> This was the same year that the movement to limit the Japanese from obtaining fishing licenses began to move beyond rumour. By 1923 they owned only 1200 less gill-net licenses, which was 800 less than in 1922.<sup>72</sup> The number of licenses issued to the Japanese were stabilized throughout the thirties, until they were eliminated in 1941 when war broke out between the Allies and Japan.<sup>73</sup>

Records of the operation of the Japanese hospital during the 1920s and 1930s have yet to be discovered. What is known is that the hospital did operate under Japanese management until

1942, when the Japanese were interred during World War II. The hospital continued operations until 1946, when the building was sold in 1946 to the Army, Navy and Air Force Veterans Club. The building was later destroyed in a fire. Yet, the Japanese hospital remains in the memories of many of the citizens of Steveston, and many of the children born there, regardless of race, were born at the Japanese hospital.

## **Summary**

An examination of the history of the Japanese hospital provided a unique opportunity to explore the development of a small community hospital from the perspective of local community leaders. From this perspective, the Japanese hospital was more than a modern health institution or training ground for health professionals. In the minds of Japanese leaders, building and operating the hospital would offer a response to racist arguments that the Japanese in British Columbia did little to contribute to the local community. The Japanese fishermen utilized Western models of medicine and hospital care, but aimed to hire Japanese community members whenever possible, even in ways that might be considered atypical today.

Over time, the hospital became closely connected to changing economic and social status of the Japanese community in Steveston. As fish prices fluctuated in favour of the canneries and hospital costs mounted, the fishermen utilized labour activism to obtain better fish prices and maintain hospital operations. The hospital would later be used as an important source of leverage for Japanese leaders during price negotiations. After much turmoil, fish licensure eventually stabilized and hospital services were expanded as more women and families arrived in Steveston. The Japanese hospital continued to operate until 1941 when the Japanese were interred during World War II. During the hospital's 41- year history, it not only provided essential health

services to the changing community, it also became an important political tool in the fight for racial and economic equality.

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- <sup>1</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 659-663.
- <sup>2</sup> See Tsuneharu Gonnami, *Historical Materials of Japanese Immigration to Canada*, eds. Norman Amor and Tsuneharu Gonnami, trans. Tsuneharu Gonnami (Tokyo, Japan: Fuji Publishing, 2000).
- <sup>3</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*.
- <sup>4</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*.
- <sup>5</sup> See for example, Kaiyi Chen, "Missionaries and the Early Development of Nursing in China," *Nursing History Review* 4 (1996): 129-49; Mary Ellen Doona, "Linda Richards and Nursing in Japan, 1885-1890," *Nursing History Review* 4 (1996): 99-128.; Sonya Grypma, *Healing Henan: Canadian Nurses at the North China Mission, 1888-1947* (Vancouver, BC: University of British Columbia Press, 2008).; Aya Takahashi, *The Development of the Japanese Nursing Profession: Adopting and Adapting Western Influences* (London: Routledge, 2011).
- <sup>6</sup> Elizabeth Simon, "Christianity and Nursing in India: A Remarkable Impact," *Journal of Christian Nursing* 26, no. 2 (2009): 88-94. doi: 10.1097/01.CNJ.0000348266.97429.6e
- <sup>7</sup> See Susan Netsel, "(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa," *Journal of Medical Humanities* 19 (1998): 257-277.; Kelm, *Colonizing Bodies*; Winifred Connerton, "American Nurses in Colonial Settings: Imperial Power at the Bedside," in *Routledge Handbook on the Global History of Nursing*, eds. P. D'Antonio, J. Fairman and J. Whelan (London: Routledge, 2013), 11-21.
- <sup>8</sup> Katrin Schultheiss, "Imperial Nursing: Cross-Cultural Challenges for Women in Health Professions: A Historical Perspective," *Policy, Politics and Nursing Practice* 11, no. 5 (2010): 151-157. doi: 10.1177/1527154410377356
- <sup>9</sup> Roy, *White Man's Province*, 81-83.
- <sup>10</sup> Ibid., 82.
- <sup>11</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*.
- <sup>12</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*.
- <sup>13</sup> Gagan and Gagan, *For Patients of Moderate Means*, 42.
- <sup>14</sup> Risse, *Mending Bodies, Saving Souls*, 463.
- <sup>15</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 643
- <sup>16</sup> Ibid., 649.
- <sup>17</sup> Ward, *White Canada Forever*, 120-121.
- <sup>18</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 649-655.
- <sup>19</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 151.
- <sup>20</sup> Vancouver General, *Third Annual Report of the Vancouver General Hospital*.
- <sup>21</sup> Ibid., 62-63.
- <sup>22</sup> Ibid., 59.
- <sup>23</sup> Ibid., 49
- <sup>24</sup> Ibid., 48-49.
- <sup>25</sup> Charles Woodward Memorial Room, "William Brenton Burnett Papers," *Charles Woodward Memorial Room*, University of British Columbia Woodward Library, Rare Cabinet 27.
- <sup>26</sup> A. McKenzie, "He Dug Out Millions," *Vancouver Province*, March 10, 1956: 5.
- <sup>27</sup> Charles Woodward Memorial Room, "William Brenton Burnett Papers."
- <sup>28</sup> Ibid.

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<sup>29</sup> Jacalyn Duffin, "The Impact of Single-Payer Health Care on Physician Income in Canada, 1850–2005," *American Journal of Public Health* 101, no. 7 (2011): 1198. doi: 10.2105/AJPH.2010.300093

<sup>30</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 59.

<sup>31</sup> Ibid., 102.

<sup>32</sup> Anne Pearson, *The Royal Jubilee Hospital School of Nursing: 1891-1982* (Victoria, BC: Alumnae Association of the Royal Jubilee Hospital School of Nursing, 1985).

<sup>33</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 64-65.

<sup>34</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 656.

<sup>35</sup> Burrows, *Healing in the Wilderness*, see ch. 1.

<sup>36</sup> Ibid.

<sup>37</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 64.

<sup>38</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 673

<sup>39</sup> Ibid., 655.

<sup>40</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 33.

<sup>41</sup> Ibid., 97-101.

<sup>42</sup> Victoria Daily Colonist, "Farming and Fishing: Steveston Sept. 8." *Victoria Daily Colonist*, September 12, 1900, accessed November 17, 2014,

<http://archive.org/stream/dailycolonist19000912uvic/19000912#page/n5/mode/1up>

<sup>43</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 109.

<sup>44</sup> Ibid., 110.

<sup>45</sup> Ibid., 111, 114.

<sup>46</sup> Information about Dr. R. R. Robinson could not be located by the British Columbia Medical Association archivist.

<sup>47</sup> Ibid., 112.

<sup>48</sup> Ibid., 113-116.

<sup>49</sup> Ibid., 117-121.

<sup>50</sup> Ibid., 121-130.

<sup>51</sup> Ibid., 138-139.

<sup>52</sup> Ibid., 139-140.

<sup>53</sup> Ibid., 140-143.

<sup>54</sup> Ayukawa, *Hiroshima Immigrants to Canada*, 84.

<sup>55</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 143-145, 148.

<sup>56</sup> Ibid., 147-148

<sup>57</sup> Ibid., 152.

<sup>58</sup> Ibid., 148-152.

<sup>59</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 673.

<sup>60</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 158.

<sup>61</sup> Ibid., 151-158.

<sup>62</sup> Ibid., 158-160.

<sup>63</sup> Ibid., 163-165.

<sup>64</sup> Ward, *White Canada Forever*, 68-69.

<sup>65</sup> Kobayashi, *Sutebusuton Gyosha Jizen Dantai 35-Nenshi*, 166.

<sup>66</sup> Nakayama, *Kanada Doho Hatten Taiken Zen*, 670.

<sup>67</sup> Ibid., 670-671.

<sup>68</sup> Ibid., 673.

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<sup>69</sup> Ibid., 678.

<sup>70</sup> Ibid., 684, 688,

<sup>71</sup> Ibid., 172.

<sup>72</sup> Ward, *White Canada Forever*, 122-123

<sup>73</sup> Ibid.

# **CONCLUSION: REFLECTIONS ON THE DEVELOPMENT OF CHINESE AND JAPANESE HOSPITALS IN BRITISH COLUMBIA**

## **Insights for Nursing, Nursing History and Historical Scholarship**

This study offers a number of important insights for nursing, nursing history and historical scholarship in Canada and beyond. Firstly, this study offers new evidence about small hospital development in Canada at the turn of the twentieth century. Much of what has previously been studied during this time period focused on the transition of the hospital from a modest charity to modern medical institution.<sup>1</sup> Guenter Risse, for example, argues that hospitals transitioned from houses of mercy, segregation and rehabilitation to houses of surgery, science and high technology.<sup>2</sup> This study adds to this history by providing important evidence about the existence of a rich diversity of smaller community hospitals in Canada prior to the establishment of the universal health care system after World War II. From 1860 to 1920, over one hundred and fifty-five hospitals were built across British Columbia. In addition to large general public hospitals there were hospitals aimed at women, children, the elderly, and specialized hospitals designed for particular diseases, like mental illness and tuberculosis. Moreover, there were hospitals intended for Aboriginal, Chinese and Japanese populations.

This study demonstrates that culture and race shaped the development of hospitals from the beginning of British Columbia's history. The development of hospitals for specific racial groups was related to the racist context of the time. For example, an 'Oriental' ward was established in the Vancouver General just after the Vancouver riot of 1907, as conflict mounted between White and Asian labourers. Similarly, New Westminster city council encouraged the

establishment of a Chinese hospital in 1892 to separate Chinese from White patients. Yet, this study reveals that hospitals aimed at particular racial groups were not always developed because of racism alone. Important contextual and community factors shaped the development of Asian hospitals in British Columbia.

This study builds upon hospital history scholarship that explores hospital development in the Canada and United States.<sup>3</sup> For example, recent scholarship exploring Canada's Indian hospitals from 1940-1970 reveals that these institutions, managed by the federal Indian Health Services varied in size and function, depending on the characteristics of nearby communities. However, Indian Health Service hospitals were distinguished by a system of centralized government decision-making, and were not as closely connected to or operated by local Aboriginal community members.<sup>4</sup>

In contrast, scholars like Patricia D'Antonio, for example, trace of the history of the Friends Asylum in Philadelphia, a mental asylum that was established by Quakers during the late 1870s.<sup>5</sup> D'Antonio argues that care was carefully negotiated by patients, managers, staff and families within the broader Quaker religious community. The history of Asian hospitals examined in this study builds upon these ideas by demonstrating the importance of community factors in the creation of hospital care. However, the history of Asian hospitals also demonstrates that some hospitals were shaped by important cultural factors, shaped by broader, economic, social and political relations.

This study adds insight to scholarship examining the role of racism and racial segregation in the development of hospitals for non-White groups during this time period.<sup>6</sup> For example, scholars who have examined the history of the development of Black hospitals in the United States, found that these hospitals were not necessarily established because of racism and required

segregation. Some were created to encourage medical and nursing training amongst Black populations, while others were created because of their proximity to Black communities.<sup>7</sup> In comparison to these findings, Asian hospitals in British Columbia came about primarily as a form of self-segregation, to provide hospital care that would be inclusive of Asian languages, beliefs and values. Additionally, the development of the Japanese hospital was employed as an important counter argument to racist rhetoric within the wider community, providing an important *Japanese* contribution to the local community.

This study adds to previous findings that racial distinctions have remained an important part of hospitals in many communities in the United States and Canada. In a study of hospitals in Kansas City between 1875 and 1920, Joan Lynaugh argues that prior to the turn of the twentieth century, patients preferred hospitals that represented their religious (e.g. Catholic, Episcopalian), ethnic (e.g. German, Swedish, Irish), and to a lesser extent racial identity.<sup>8</sup> Yet, by 1920, there was less demand for these religious and ethnic distinctions. This change was thought to correspond with decreasing immigration, increasing assimilation of second and third generations, and because of the increasing social acceptability of hospital care, over care in the home. Yet as older and larger hospitals in Kansas City began to serve a wider cross-section of the population, a new Black hospital was built in 1913. This, as Lynaugh points out, represents an important exception to the assimilation of hospitals. This study adds to these observations by demonstrating that the operation of Asian hospitals continued, despite decreasing Asian immigration between 1920 and 1945 and the passing of Canada's Multicultural Act in 1988, which promoted the acceptance of cultural diversity and protection of minority rights. Today, for example, Vancouver's Mount Saint Joseph's and Victoria's Chinatown Care Centre continue a tradition of

caring for citizens of Chinese heritage. These findings demonstrate that culture and race continue to be important distinctions shaping hospital care in Canada.

Though scholars have begun to examine the history of hospitals related to Aboriginal,<sup>9</sup> Chinese<sup>10</sup> and Japanese<sup>11</sup> populations in Canada, few have compared and contrasted hospital development between these groups. At the outset of this study, I highlighted important differences in the development of Chinese and Japanese hospitals during the turn of the twentieth century. Influenced in-part by the anti-Asian context of the time, there were important cultural and political differences, within Canada and abroad that resulted in the differences between the hospitals discussed in this study. For Chinese communities, hospitals were built as modest charitable establishments for the sick and destitute, utilizing Chinese, rather than Western medicine. Those who operated Chinese hospitals did not utilize Western ideas about hospitals and health care until much later than Japanese populations. The delayed utilization of Western ideas was influenced by China's anti-foreign campaign that began after Western countries imposed unequal treaties in China during the mid-1800s.

For Japanese populations in Canada, there was a clear ambition to build a modern hospital, utilizing doctors and nurses trained in Western medicine. These ideas were influenced by the campaign of modernization and militarization that swept through Japan during the Meiji period (1868-1912). For Japanese leaders in Canada, it was believed that a modern hospital in Steveston could provide more than health care, the hospital could also provide protection against racist rhetoric, unfair economic restrictions and other anti-Asian policy.

In addition to the comparisons made between Chinese and Japanese hospital development, I discuss important distinctions in the development of Asian and Aboriginal hospitals. Aboriginal peoples seem to have had less involvement in hospital development, in that

hospitals were primarily missionary or government initiatives.<sup>12</sup> Moreover, Aboriginal peoples were educated and employed as physicians and nurses much later than their Asian counterparts.<sup>13</sup> Yet, further scholarly study of the development of Aboriginal hospitals during the turn of the twentieth century is warranted to substantiate or refute these particular claims, as most of the current scholarship focuses the history of these hospitals after the 1920s.<sup>14</sup>

The examination of the role of Methodist missionaries in the development of the Japanese hospital adds unique contributions to nursing historiography about mission work during the mid-1800s to early 1900s. Much has been written about the introduction of professional nursing to non-Western countries,<sup>15</sup> as well as the involvement of various Catholic orders in hospital and health care development in North America.<sup>16</sup> This study reveals that in addition to foreign missions, Methodist missionaries were involved in a diverse range of “Home Missions” within Canada, including many targeted at non-White groups, including Aboriginal, Chinese and Japanese populations. Moreover, Methodist medical mission work amongst these groups differed considerably, particularly with regards to the Japanese hospital mission.

The history of the Japanese mission hospital reveals that medical mission work was not as simple as White missionaries establishing hospitals for non-White groups. In this study, Japanese Christian missionaries themselves became involved in the fishing camps at the mouth of the Fraser River, and it was their idea to engage in hospital work. These findings provide an important divergence from the popular idea in nursing history that medical missionaries worked to further the imperial agenda of Western powers.<sup>17</sup> In this case, Japanese missionaries utilized Christianity and Western ideas about hospital development to confront racist ideology and lessen the divide between Asian and White populations.

From the onset, this study was designed utilizing a broadened perspective of nursing history, one which would allow not only for the examination of the stories and experiences of nurses, but also for a critical examination of the contexts of nursing practice. In contrast to much of what is known about hospital development during this time period, this study challenges the idea that Western trained medical professionals were always at the core of hospital development. In this study, nurses were present and important, especially to the Japanese hospital, but Asian hospitals were primarily developed as community strategies. Although racial tensions and illness amongst Chinese and Japanese workers created a need for hospital care, community leaders, with little knowledge of medicine or nursing, led the establishment of Asian hospitals.

This study reveals that smaller community hospitals were often more reliant, than large general public hospitals, on local geographic, economic and political factors. The Japanese hospital, for example, was established because of a large number of sick Japanese workers in the small fishing village of Steveston. The economic success of the Japanese fishermen allowed them to build and operate a larger hospital than what was possible in many similarly sized communities in British Columbia. Small community hospitals were often funded by a combination of charitable and government sources. Yet, the Japanese hospital was reliant on the yearly membership fees of the Japanese fishermen. Through this system, the hospital board was challenged to find funding when unexpected expenses arose, but it also allowed the Japanese community control over a most important local health resource. Without this service, sick Japanese workers would have to travel far from home, and the care they received would have been provided without the familiar comfort of Japanese language, culture and food.

For the Japanese community in Steveston, community control of the Japanese hospital allowed the Japanese Benevolent Association to adjust and negotiate care in ways that would be

considered unusual today. For example, untrained Japanese men were utilized as nurses during the first few years of the operation of the mission hospital. Japanese personnel were employed in the hospital wherever possible, including a Japanese medical student who was hired as a nurse at the modern hospital. These adjustments provided Japanese community members opportunities that otherwise would have been difficult to obtain in Canada during the anti-Asian context of the time.

### **Limitations**

One limitation of this study was the lack of primary sources, especially regards to nursing-related records. From the onset, it was my hope that I would learn more about how nurses within these hospitals practiced and understood care of various cultural populations, however, such records could not be located. Another limitation of the study was that because many primary sources were written in Chinese or Japanese languages, it was not a straightforward process (for an English-speaking researcher like myself) to assess or access records, and there could potentially still be sources of interest that require translation.

### **Implications**

This study demonstrates that hospital development in Canada has been shaped by more than industrialization, urbanization or the introduction of modern scientific medicine and professionalization of nursing.<sup>18</sup> Hospitals have also been shaped by important cultural and community contexts, influenced by a swiftly changing economic and political landscape. Further examination of the development of hospitals in Canada is warranted and will require analysis of records beyond typical hospital records, which are often limited to the perspective of board members and hospital staff. Further study of Western Canada's rural, remote and Northern

hospitals will provide important information with which to compare and contrast with the findings of this study.

Another significant implication of this study is that it highlights the value of utilizing a critical theoretical perspective of culture to explore cultural and racial relations in nursing research. The use of this lens extended the analysis of Asian hospital development beyond a mere examination of racial or cultural differences, and encouraged exploration and linkage to the influence of broader political, economic and social power relations. In this study, I provide many examples of how the development of Chinese and Japanese hospitals were linked to important political, economic and social contexts, both in Canada and abroad. For instance, I examined motivations for emigration and immigration, the hardships of economic activities, such as a fishing industry, as well as the influence of the broader social structures, like the anti-Oriental context of the time.

The use of a critical lens of culture encouraged an examination of the complexities of culture and related power relations in this study. I specifically attempted to complicate the analysis by examining cultural influences related to the development of Asian hospitals beyond the typical understanding of White as dominant and non-White as subordinate. I primarily achieved this type of analysis by bringing attention to people who operated from beliefs, motivations and understandings that did not easily fit into conventional cultural categories, such as Canadian or Japanese. This analysis emphasized, for example, that several of the Methodist missionaries, viewed themselves as a kind of ‘go-between,’ calling into question and demonstrating the complexity that exists within and between traditionally defined cultural groupings.

This study provides some important insights for nursing scholars interested in culture and cultural care theory in nursing. Ideas such as cultural competence and cultural safety have often been linked to the need to be more culturally sensitive to and less ethnocentric of cultural and racial groupings in health care. However, little has been written about what occurred in regards to these issues in the past, as it relates to a context (prior to WWII) that is often considered more overtly racist. In this study, I argue that Asian hospitals were not merely examples of mandated racial segregation. The development of these hospitals was linked to the racist context of time, but racial tensions were often utilized to obscure or inflame important economic and political conflicts amongst workers in British Columbia. Understanding the history of British Columbia's Asian hospitals during a period of colonialism and population expansion may encourage nurses to think critically about the connectedness of racial power relations to economic and political tensions. Today's cultural groupings are historically constructed and exploring past instances of racism and prejudice can provide an opportunity to discuss these uncomfortable topics in relation to nursing and nursing contexts.

As a final point, this study demonstrates that hospitals can be viewed as more than places to care for the sick or cure illness. Both Chinese and Japanese hospitals were community controlled and offered care that included familiar customs and traditions. The Japanese hospital was utilized as a source of leverage for the Japanese fishermen during fishing price negotiations and to defend against rejectionist arguments. These findings reveal that hospitals can also operate as important political tools in the struggle for racial and economic equality. Accordingly, hospitals and the communities that define them, play an important role in broader issues of social justice in health care.

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<sup>1</sup> Gagan and Gagan, *Patients of Moderate Means.*; Risse, *Mending Bodies, Saving Souls*.

<sup>2</sup> Risse, *Mending Bodies, Saving Souls*, 675-677.

<sup>3</sup> Katherine Burnett, "The Healing Work of Aboriginal Women in Indigenous and Newcomer Communities," in *Place and Practice in Canadian Nursing History*, eds. Jane Elliott, Meryn Stuart and Cynthia Toman (Vancouver, BC: University of British Columbia Press, 2008).; D'Antonio, *Founding Friends.*; Meijer Drees, *Healing Histories.*; Long and Golden, eds. *The American General Hospital: Communities and Social Contexts.*; Risse, *Mending Bodies, Saving Souls*.

<sup>4</sup> Ibid.

<sup>5</sup> D'Antonio, *Founding Friends*.

<sup>6</sup> Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement 1920-1945*, (New York, NY: Oxford University Press, 1995).

<sup>7</sup> Northington Gamble, "The Negros Hospital Renaissance."

<sup>8</sup> Lyнаugh, "From Respectable Domesticity to Medical Efficiency."

<sup>9</sup> See Meijer Drees, *Healing Histories.*; Kelm, *Colonizing Bodies*.

<sup>10</sup> Lai, *From Self-Segregation to Integration.*; Turcotte, "Hospitals for Chinese in Canada."

<sup>11</sup> See Osterhout, *Orientals in Canada*.

<sup>12</sup> Burrows, *Healing in the Wilderness.*; Meijer Drees, *Healing Histories.*; Kelm, *Colonizing Bodies*.

<sup>13</sup> Meijer Drees, *Healing Histories*.

<sup>14</sup> Meijer Drees, *Healing Histories.*; Meijer Dress and McBain, "Nursing and Native Peoples in Northern Saskatchewan."

<sup>15</sup> Chen, "Missionaries and the Early Development of Nursing in China."; Doona, "Linda Richards and Nursing in Japan, 1885-1890."; Grypma, *Healing Henan.*; Netsel, "(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa."

<sup>16</sup> See Gauthier, *Women without Frontiers.*; Nelson, *Say Little, Do Much.*; Wall, *American Catholic Hospitals*.

<sup>17</sup> Schultheiss, "Imperial Nursing."

<sup>18</sup> Gagan and Gagan, *Patients of Moderate Means.*; Risse, *Mending Bodies, Saving Souls*.

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