

CAREER CONTINGENCIES OF ENGLISH-MONTREAL PHYSICIANS

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SUMMARY

This study replicates one by David N. Solomon of Chicago physicians, by asking similar questions about English-Montreal medicine. Included are 1,414 physicians and 30 hospitals. It examines statistically whether a marked ethnic/religious and class system exists among hospitals, and whether a physician's birthplace and medical school affect where he practices in the system. An examination of numerous hospital characteristics finds such a class system among the hospitals. In considering birthplace and medical school backgrounds, typical career sequences and life chances of physicians are found associated with the prestige of different hospital categories. In general we find that physicians with readily-assimilable birthplace/medical school backgrounds have greater representation and more chances of affiliation at the high-prestige hospitals. The opposite holds true for physicians with "different" backgrounds. Particular characteristics are noted about careers in minority-group and special hospitals, and about mobility of Canadian physicians within Canada.

(Title)

CAREER CONTINGENCIES OF ENGLISH-MONTREAL PHYSICIANS

McGILL UNIVERSITY

CAREER CONTINGENCIES OF ENGLISH-MONTREAL PHYSICIANS

A THESIS SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
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BY
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To my father

PREFACE

This study is an attempt to understand, through the analysis of mostly statistical data, how the hospital system of a community is structured; what are the implications of this structure for physicians' careers; and what are the patterns of selection of physicians into different parts of the system. It also presents data not available in another source on social characteristics of the community's medical profession. Although not part of the main argument of this study, I hope the latter may be of some use to persons interested in medical sociology generally, or specifically in the organization of medical practice in English Montreal.

I especially want to thank Professor David N. Solomon for suggesting this research topic; for making many personal contacts that facilitated access to the data and helped my work; and for the theoretical and technical assistance and personal support and encouragement he supplied throughout the project as my principal thesis adviser.

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Virtually all my data were supplied by the College of Physicians and Surgeons of the Province of Quebec. I would

not have been able to carry out as complete and extensive a study of physicians without the generous cooperation and material provided by the College. I am very grateful to Augustin Roy, M.D., Registrar of the College of Physicians and Surgeons of the Province of Quebec, for supplying this material and giving freely of his time and attention to the many problems of detail that arose during the study.

I gratefully acknowledge the considerable time and effort that Michel Mailloux and Astrid Pelletier spent with me, explaining and exploring the complexities of the data. They were both employed at the time in the Centre de Mécanographie of the College of Physicians and Surgeons of the Province of Quebec.

I want to express my gratitude for the work done by Phil Lamb, of the McGill Computing Center, in computer programming and operating connected with this project. What started as an instrumental relationship became one of friendship, and his generous use of his time provided me with much more knowledge of the mechanics of data processing than I would normally have received.

I want to thank the following persons who assisted with my project. Victor C. Goldbloom, M.D., M.P.P., introduced me to the College of Physicians and Surgeons of the Province of Quebec and facilitated my access to its documentary and statistical material. Hans Sievers, of Georges Demers Ltée., executed the maps in Appendix E. Mrs. W. G. Simpson, of Ottawa, typed the manuscript. Allan Steinberg,

of McGill University, coded physicians' hospital affiliations.

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TABLE OF CONTENTS

	Page
PREFACE	iii
LIST OF TEXT TABLES	ix
LIST OF APPENDIX TABLES	x
LIST OF APPENDIX MAPS	xvii
ABBREVIATIONS	xviii
 Chapter	
I. INTRODUCTION	1
Review of the Relevant Literature	2
Purpose of the Research	7
Outline of the Chapters	7
II. THE PHYSICIANS AND HOSPITALS OF ENGLISH MONTREAL	9
English Montreal	9
English-Montreal Physicians	13
Statistical Data on English-Montreal Physicians	14
English-Montreal Hospitals	15
Data on English-Montreal Hospitals	16
Interviews	17
III. STATUS CHARACTERISTICS OF ENGLISH HOSPITAL CATEGORIES	18
Methodology	22
General Hospitals	23
Classification of Hospitals	23
The Sponsors of Hospitals	24
Formal Approval of Hospitals	28
Size, Expenditures and Endowments	33
Characteristics of Physicians	35
Special Hospitals	45
Classification of Hospitals	45
The Sponsors of Hospitals	46
Formal Approval of Hospitals	48
Size, Expenditures and Endowments	51
Characteristics of Physicians	52
Summary	57

TABLE OF CONTENTS--Continued

Chapter	Page
IV. ATTENDING PHYSICIANS: STAFF DUPLICATION	60
Staff Duplication	60
Rules for Controlling Staff Duplication	64
Discussion and Conclusions	71
V. BIRTHPLACE AND MEDICAL SCHOOL: ELEMENTS OF THE SORTING PROCESS	72
Purpose	73
Hypothesis	74
Variables	76
General-Hospital Physicians: Characteristic Careers in Hospital Categories	79
All Physicians: Characteristic Careers in Hospital-Affiliation Categories	91
Career Contingencies as Life Chances	101
VI. SUMMARY AND INTERPRETATION OF FINDINGS	112
Summary	112
Interpretation of Findings	117
Further Research	122
Appendix	
A. EXPLANATION OF TERMS	128
Physicians	129
Hospitals	132
B. DATA ON ENGLISH-MONTREAL HOSPITALS	146
C. DATA ON STAFF DUPLICATION AMONG ATTENDING PHYSICIANS.	190
D. BIRTHPLACE AND MEDICAL SCHOOL DATA	201
E. MAPS AND POPULATION TABLES: MONTREAL	230
F. MISCELLANEOUS	254
Comparison of English-Montreal Physicians, and Attending Physicians at English- Montreal Hospitals	255
Questionnaire of the College of Physicians and Surgeons of the Province of Quebec	258

TABLE OF CONTENTS--Continued

Appendix	Page
F. MISCELLANEOUS--Continued	
Data Collected on Each Quebec Physician by the College of Physicians and Surgeons of the Province of Quebec, and Retained on Magnetic Tape	260
Information Requested from Montreal Hospitals.	262
Interviews	263
G. PHYSICIANS OF ENGLISH MONTREAL: SOCIAL CHARACTERISTICS	264
BIBLIOGRAPHY.	289

LIST OF TEXT TABLES

Table	Page
<p>1. Summary Table Showing the More Common Career Sequences (in Percentage) in Each Hospital Category: General-Hospital Physicians</p>	81
<p>2. Summary Table Showing the More Common Career Sequences (in Percentage) in Each Hospital-Affiliation Category: All Physicians.</p>	93
<p>3. Summary Table Showing Over- and Under-Representations (in Percentage Points) of Physicians with Particular Birthplace/Medical School Backgrounds (Compared to All Physicians) by General-Hospital Category.</p>	103
<p>4. Summary Table Showing Over- and Under-Representations (in Percentage Points) of Physicians with Particular Birthplace/Medical School Backgrounds (Compared to All Physicians) by Hospital-Affiliation Category.</p>	104

LIST OF APPENDIX TABLES

Table		Page
APPENDIX B		
B:1.	List of English Hospitals, Showing Hospital-identification Number, Full Name and Abbreviated Name; and Purpose of Each of the Special Hospitals	147
B:2.	List of General-hospital Categories, Individual Hospitals Included, Date of Establishment, and Nature of Sponsorship. .	149
B:3.	General Hospitals: Elements of Formal Approval, Part One	151
B:4.	General Hospitals: Elements of Formal Approval, Part Two	153
B:5.	General Hospitals Approved for Residency Training: Number of Residents on Staff, and Number of Specialties for Which Training is Approved	155
B:6.	General Hospitals: Number of Beds, Total Expenditures Per Bed, and Endowment Funds in Total and Per Bed, 1965	157
B:7.	Percentage Distribution of Physicians by General Hospital and by Ethnic Origin . . .	159
B:8.	Percentage Distribution of Physicians by General Hospital and by Specialization Characteristics	161
B:9.	Physicians at General Hospitals, Showing Proportions who are Consultants, Teachers, or Researchers	163
B:10.	Percentage Distribution of Physicians by General Hospital and by Office Location . .	165
B:11.	List of Special-hospital Categories, Individual Hospitals Included, Date of Establishment, and Nature of Sponsorship. .	167

LIST OF APPENDIX TABLES--Continued

Table	Page
APPENDIX B--Continued	
B:12. Special Hospitals: Elements of Formal Approval, Part One	169
B:13. Special Hospitals: Elements of Formal Approval, Part Two	171
B:14. Special Hospitals Approved for Residency Training: Number of Residents on Staff, and Number of Specialties for Which Training is Approved	173
B:15. Special Hospitals: Number of Beds, Total Expenditures per Bed, and Endowment Funds in Total and per Bed, 1965	175
B:16. Percentage Distribution of Physicians by Special Hospital and by Ethnic Origin . . .	177
B:17. Percentage Distribution of Physicians by Special Hospital and by Specialization Characteristics.	179
B:18. Physicians at Special Hospitals, Showing Proportions Who Are Consultants, Teachers, or Researchers	181
B:19. Percentage Distribution of Physicians by Special Hospital and by Office Location . .	183
B:20. Percentage Distribution of Physicians by Type of Hospital-staff Affiliation and by Ethnic Origin	185
B:21. Percentage Distribution of Physicians by Type of Hospital-staff Affiliation and by Specialization Characteristics	187
B:22. Physicians by Type of Hospital-staff Affiliation: Showing Proportions Who Are Consultants, Teachers or Researchers	188
B:23. Percentage Distribution of Physicians by Type of Hospital-staff Affiliation and by Office Location	189

LIST OF APPENDIX TABLES--Continued

Table	Page
APPENDIX C	
C:1.	Percentage Distribution of Physicians by Number of Attending Positions Held and by Medical-type of Hospital; also Showing Total Attending Positions Held and Their Number per 100 Attending Physicians
	191
C:2.	General-hospital Categories, Showing Number of Attending Positions and Attending Physicians, Number of Partial-affiliation and Consulting Physicians, and Percentage of Attending Physicians with Partial Affiliation Elsewhere
	192
C:3.	Special-hospital Categories, Showing Number of Attending Positions and Attending Physicians, Number of Partial-affiliation and Consulting Physicians; and Percentage of Attending Physicians with Partial Affiliation Elsewhere
	194
C:4.	General-hospital Categories, Showing Percentage Distribution of Attending Physicians by Number of Attending Positions Held, Showing Number of Attending Positions per 100 Attending Physicians, and Total Attending Positions Held and the Percentage of Such Held Outside the Category
	195
C:5.	Special-hospital Categories, Showing Percentage Distribution of Attending Physicians by Number of Attending Positions Held, Showing Number of Attending Positions per 100 Attending Physicians, and Total Attending Positions Held and the Percentage of Such Held Outside the Category.
	196
C:6.	General-hospital Attending Physicians by General-hospital Category, Showing Per- centage with Attending-staff Affiliation in the English-Montreal Hospital Categories .
	197
C:7.	Special-hospital Attending Physicians by Special-hospital Category, Showing Percentage with Attending-staff Affiliation in the English-Montreal Hospital Categories
	198

LIST OF APPENDIX TABLES--Continued

Table	Page
APPENDIX C--Continued	
C:8. Physician/hospital Categories, Showing Number of Physicians in the Category, Number of Excluded Physicians, and a Description of Physicians Included in the Category	199
APPENDIX D	
D:1. Percentage Distribution of General-hospital Physicians by Medical School and Birthplace, Hospital Category Held Constant . . .	208
D:2. Percentage Distribution of All Physicians by Medical School and Birthplace, Hospital-Affiliation Category Held Constant	212
D:3. Over- and Under-representation of Physicians with Particular Birthplace/Medical School Backgrounds (Compared to All Physicians) in General-hospital Categories	217
D:4. Over- and Under-representation of Physicians with Particular Birthplace/Medical School Backgrounds (Compared to All Physicians) in Hospital-affiliation Categories	218
D:5. Percentage Distribution of All Physicians by General-hospital Category for Major Categories of Birthplace and Medical School	219
D:6. Percentage Distribution of All Physicians by Hospital-affiliation Category for Major Categories of Birthplace and Medical School	221
D:7. Percentage Distribution of All Physicians by Type of Hospital-staff Affiliation and Birthplace	223
D:8. Percentage Distribution of All Physicians by Type of Hospital-staff Affiliation and Medical School--Part One, Canadian Medical Schools	224

LIST OF APPENDIX TABLES--Continued

Table	Page
APPENDIX D--Continued	
D:9. Percentage Distribution of All Physicians by Type of Hospital-staff Affiliation and Medical School--Part Two, Foreign Medical Schools	225
D:10. Percentage Distribution of Physicians Having <u>Both</u> Voluntary General (G1 to G5) and Voluntary Acute-special (S1 to S3) Attending Affiliation, by Medical School and Birthplace.	226
D:11. Percentage Distribution of General-hospital Physicians Born and Educated (Medical School) Abroad by Hospital Category and Number of Years in Canada--Physicians Born in English and Non-English Countries Shown Separately	227
D:12. Percentage Distribution of All Physicians Born and Educated (Medical School) Abroad by Hospital-affiliation Category and Number of Years in Canada--Physicians Born in English and Non-English Countries Shown Separately.	228
APPENDIX E	
E:1. Population of Metropolitan Montreal by Statistical Area and Ethnic Origin, 1961.	241
E:2. Percentage Distribution of the Population of Metropolitan Montreal by Ethnic Origin and Statistical Area, 1961.	244
E:3. Population of Metropolitan Montreal by Official Language Spoken and Statistical Area, 1961	246
E:4. Percentage Distribution of the Population of Metropolitan Montreal by Official Language Spoken and by Statistical Area, 1961.	248
E:5. Population of Metropolitan Montreal by Ethnic Origin and by Official Language Spoken, 1961	249

LIST OF APPENDIX TABLES--Continued

Table	Page
APPENDIX E--Continued	
E:6.	Percentage Distribution of the Population of Metropolitan Montreal by Official Language Spoken and by Ethnic Origin, 1961
	250
E:7.	Metropolitan Montreal and the Montreal Region: Population Density by Concentric Zone, 1961
	251
APPENDIX F	
---	Table Showing, for Certain Hospitals, Total Number of Attending Physicians on Hospital List, Number of Such Physicians Excluded from the Population Studied and Reason for Exclusion, and Number of Attending Physicians Included in the Study.
	256
APPENDIX G	
G:1.	Percentage Distribution of Physicians by Type of Hospital Affiliation and by Age. . .
	273
G:2.	Percentage Distribution of Physicians by Type of Hospital Affiliation, and by Sex, by Number of Years of Practice in Quebec, and by Number of Years Since Graduation from Medical School.
	276
G:3.	Percentage Distribution of Physicians with Quebec College Specialty Certification by Type of Hospital Affiliation and by Specialty Category
	277
G:4.	Percentage Distribution of Physicians by Type of Hospital Affiliation and by Main Professional Activity
	279
G:5.	Percentage Distribution of Physicians by Type of Hospital Affiliation, and by Professional Activity and Number of Professional Activities
	281

LIST OF APPENDIX TABLES--Continued

Table		Page
APPENDIX G--Continued		
G:6.	Percentage Distribution of Physicians by Type of Hospital Affiliation and by Main Source of Professional Income	283
G:7.	Percentage Distribution of Physicians by Type of Hospital Affiliation, and by Source of Professional Income and Number of Income Sources.	285
G:8.	Percentage Distribution of Physicians by Form of Remuneration, and by Preferred Language	287

LIST OF APPENDIX MAPS

Map	Page
APPENDIX E	
1. Metropolitan Montreal as Defined in the Study, Showing Cities, Towns, Villages and Other Organized Areas	235
2. Metropolitan Montreal Showing Statistical Subdivisions Used in the Study	236
3. Metropolitan Montreal Showing Location and Type of English Hospitals	237
4. Metropolitan Montreal Showing Location and Identification Number of English Hospitals	238
5. Part of Metropolitan Montreal, Showing the Downtown Area, the West-Center, and East Center Statistical Areas, and the Location and Identification Number of English Hospitals	239
6. The Montreal Region	253

ABBREVIATIONS

The following abbreviations are used frequently in the study.

Journals

American Sociological Review: ASR
American Journal of Sociology: AJS
Canadian Journal of Economics and Political Science: CJEPS
Canadian Medical Association Journal: CMAJ
Journal of Health and Human Behavior: JHHB

Other Abbreviations

College of Physicians and Surgeons of the Province of
Quebec: Quebec College
Department of National Health and Welfare (Canada): DNHW
Dominion Bureau of Statistics (Canada): DBS
Royal College of Physicians and Surgeons of Canada:
Royal College

CHAPTER I

INTRODUCTION

A career is usually thought of as the more or less orderly and planned succession of statuses and roles of an individual within the work situation of his profession.¹ As regards his career, the profession is the most immediate social system within which the person interacts.² The profession, of course, is also a part of the larger social system, the society in which it is located.

It is generally accepted in sociology that an individual's personal and social characteristics affect his position within a social system. Upon entering a profession, an individual brings with him those personal characteristics that may influence his social position. During the process of socialization into the profession he also acquires characteristics that have important implications for his career.

¹See for example, Ernest Greenwood, "Attributes of a Profession," and Howard S. Becker, "The Career of a School-teacher," in Sigmund Nosow and William H. Form (eds.), Man, Work, and Society (New York: Basic Books Inc., 1962), pp. 215-16 and p. 321.

²Except, possibly, for professionals in bureaucratic organizations. See David N. Solomon, "Professional Persons in Bureaucratic Organizations," Walter Reed Army Institute of Research, Symposium on Preventive and Social Psychiatry (Washington, D.C.: 1957), pp. 253-65.

This study attempts to examine the interrelationships among birthplace, medical school and hospital affiliation in the career sequences of English-Montreal¹ physicians. It seeks to answer the following questions: How do the community's hospitals differ in ethnic/religious and class characteristics--and thus in prestige? What are the implications for medical careers of these prestige differences? And how do birthplace and medical school influence the sorting of physicians into different parts of the hospital system? Finally, how do physicians' other social characteristics differ with particular types of hospital affiliation?

Review of the Relevant Literature

Among the major professions, medicine appears to have received more attention from sociologists than the legal, religious, military or teaching professions. Parsons has called medicine the "prototype" of a profession and has made it the central model in applying his theoretical framework to social reality.²

Empirical research on the medical profession in North America began with the work of Everett C. Hughes at the University of Chicago. Hughes emphasized the importance of occupations

¹Since this is a study of English-Montreal physicians and hospitals, when we speak of "physicians" and "hospitals" without further qualification, from now on in the study, it should be understood that we are referring to English Montreal. To emphasize this point where it seems necessary we will speak of "English" physicians and hospitals. "English Montreal," "English-Montreal Physicians," and "English-Montreal Hospitals" are explained in Chapter II.

²Talcott Parsons, The Social System (New York: The Free Press, 1959), Chapter X, "Social Structure and Dynamic Process: The Case of Modern Medical Practice," pp. 428-79.

and the work environment. He helped to develop for the study of occupations and professions such useful concepts as status and role, reference groups, careers, the search for personal identity through the succession of jobs and occupations, and the contingent nature of careers. Nearly all Hughes' theoretical articles are relevant to study of the professions.¹ He was apparently the first to apply the concept of "contingency" to careers, to denote those social characteristics on the basis of which individuals are sorted into an occupational system.² Hughes' students began the collection and analysis of data on physicians.

The work of Weber is significant here. Although he did not use the term, "contingency," he emphasized the "decisive" or "external conditions" which affect the fate of members of an occupational group.

The following would appear to be the best developed definition and explanation of career contingencies:

The concept refers to conditions of the social system surrounding an occupation which are decisive for the success of the practitioners. Success in an occupation is contingent upon solving the problems, resolving the dilemmas and passing the hurdles or obstacles which arise from the system of social interaction in which the occupational role is set. Career contingencies are the features of this social system which decisively determine the life chances of those who have chosen the occupation as a career.

.
The day-to-day interaction in a career can be thought of as an orbit in some system or subsystem. Careers

¹See for example, Everett C. Hughes, Men and Their Work (Glencoe, Illinois: The Free Press, 1958).

²David N. Solomon, "Ethnic and Class Differences among Hospitals as Contingencies in Medical Careers," AJS, LXVI (March, 1961), p. 463. In later references this title is sometimes abbreviated--"Ethnic and Class Differences . . ."

differ in the character and boundaries of the subsystems in which they have their orbits. For medical careers, one of the obviously significant contingencies, or perhaps the obviously significant contingency, is which of these subsystems is to be the arena in which the career will be pursued. From the point of view of any particular practitioner, the kind of career he is to have and the degree of success he is likely to achieve depend on how he fits into the scheme of segmentation and stratification.¹

The early empirical study of the medical profession in North America was carried out by Oswald Hall.²

David N. Solomon used statistical and interview techniques to research in considerable detail the careers of physicians in Chicago.³ His work was the first to study statistically the typical career sequences of physicians in a major urban center. He examined sequences of medical school, location of internship/residency and hospital affiliation, with particular emphasis on how the first two factors affect a physician's position in the hospital system considered in its ethnic/religious and class dimensions. He found a definite pattern of graduating from one of a small number of medical schools, then interning at one of the high-prestige hospitals, then gaining

¹Ibid., pp. 463-64 and p. 471. Another work that employs this concept is, Edward Gross, Work and Society (New York: The Thomas Y. Crowell Co., 1958), pp. 196-201.

²"The Informal Organization of Medical Practice in an American City" (unpublished Ph.D. dissertation, Department of Sociology, University of Chicago, 1944). See also Oswald Hall, "The Informal Organization of the Medical Profession," CJEPS, XII (1946), pp. 30-44; "The Stages of a Medical Career," AJS, LIII (March, 1948), pp. 327-36; and "Types of Medical Careers," AJS, LV (November, 1959), pp. 243-53.

³"Career Contingencies of Chicago Physicians," (unpublished Ph.D. dissertation, Department of Sociology, University of Chicago, 1952); and "Ethnic and Class Differences . . .," op. cit. In later references the former title is sometimes abbreviated--"Career Contingencies . . ."

affiliation with one of these elite hospitals. Conversely, his data showed that physicians affiliated with the category of residual hospitals--other than the Jewish and Catholic--were drawn from a much more heterogeneous set of medical schools and locations of internship/residency. The formally Jewish and Catholic hospitals he found to be ranked between these two extremes. Through this type of statistical analysis he was able to trace "characteristic careers" in different hospital categories. The present study is an attempt to replicate as closely as possible for English Montreal the statistical part of Solomon's study.¹

Although considerable attention has been given to the social backgrounds and career orientations of medical students,² little research has been done recently on careers of practising physicians.³

¹Solomon in addition interviewed a random sample and a selected sample of the physicians in his study. His interview data gave qualitative evidence of the importance of hospital affiliation in a physician's career; and of how the process of gaining access to hospital facilities and the structure of physicians' career orientations are shaped by their relations to hospitals, that is by the class of their hospital affiliation. "Career Contingencies . . ." op. cit., pp. 71-154.

²The outstanding work here is Robert K. Merton, G. C. Reader and P. L. Kendall, The Student Physician (Cambridge, Mass.: Harvard University Press, 1957). In Canada, a continuing project is being carried out by Dr. D. G. Fish, Director of Research, Association of Universities and Colleges of Canada, studying first-year medical students at the 13 Canadian medical schools. See for example, J. H. Mount and D. G. Fish, "Canadian Medical Students' Interest in General Practice and the Specialties," CMAJ, Vol. 94 (April 2, 1966), pp. 723-28; and D. G. Fish, "A Research Program in Medical Education in Canada," CMAJ, Vol. 92 (April 3, 1965), pp. 694-97.

³A recent notable exception is this study of career orientations of public-hospital physicians: William L. Graves, "Physicians and State Hospitals: The Decision to Participate" (unpublished M.A. thesis, University of North Carolina, Chapel Hill, 1961).

Some very valuable work has been done at the Master-of-Arts level in the sociology of medicine at McGill University.¹ We should mention also an important study recently done at l'Université de Montréal,² in which the author compares professional success (réussite) among the French Canadian, British Isles, Jewish, and other non-French medical communities. In addition to its theoretical contribution this study is a valuable source of statistical and graphical data on the total Montreal medical system.

¹See Bernice Peritz Loeb, "The First Years of Medical Practice: A Study of the Initiation of Medical Practice by 52 Montreal Jewish Physicians" (unpublished M.A. thesis, McGill University, 1959); Patricia G. Robinson, "A Case Study of Psychiatry in Relation to Other Medical Specialties in a Hospital" (unpublished M.A. thesis, McGill University, 1953); Jacques Brazeau, "The French-Canadian Doctor in Montreal: A Study of Careers in a Profession" (unpublished M.A. thesis, McGill University, 1951); Huntley F. McKay, "Sociological Analysis of a Group Practice: Its Effects upon the Doctor and the Hospital" (unpublished M.A. thesis, McGill University, 1950); Agnes Ferencz, "The Impact of Urbanization on French Canadian Medical Attitudes" (unpublished M.A. thesis, McGill University, 1945); Rosalynd Gold, "Occupational Selection and Adjustment in the Jewish Group in Montreal with Special Reference to the Medical Profession" (unpublished M.A. thesis, McGill University, 1942).

²Guy Demers, "Appartenance Ethnique et Réussite Professionnelle des Médecins du Grand Montréal" (unpublished M.A. thesis, l'Université de Montréal, 1965). Demers' study differs from the present one in that he focused upon how the four main ethnic groups in Montreal medicine measure up to a standard of professional success, with particular emphasis upon comparison between the French-speaking and the English-speaking. The present study takes one of these two main categories--English-speaking for the most part--and examines in greater depth its medical system, and its internal differences in professional success and in career sequences. Any reader interested in the total picture of medicine in Montreal, however, ought to consult Demers' fine study.

Purpose of the Research

The main objectives of the present research are, (1) to determine whether the English hospitals have marked ethnic/religious and class characteristics, and how the hospitals may be categorized in terms of these characteristics, (2) to examine whether physicians' birthplaces and medical schools are decisive in sorting them into different classes of the hospital class system, and (3) to present data on social characteristics of physicians by main type of hospital affiliation for the reader with an interest in medical practice in English Montreal.

Outline of the Chapters

Chapter II discusses the physicians and hospitals, and the orientation and methodology of the study.

Chapter III and Appendix B examine the ethnic/religious and class characteristics of the hospitals.

Chapter IV and Appendix C look into the fact of hospital-staff duplication, and attempt to control for it in order to make more meaningful our examination of the sorting of physicians into the hospital system.

Chapter V and Appendix D examine the influence of birthplace and medical school on the sorting of physicians into the hospital system.

Chapter VI is a summary and interpretation of findings.

Appendix A presents explanations of some more important terms used.

Appendix E presents maps showing the locations of English hospitals, and tables showing the location and languages spoken

by the ethnic groups of Montreal.

Appendix F displays miscellaneous documents and information connected with the study.

Appendix G presents data on social characteristics of English physicians by main type of hospital affiliation.

CHAPTER II

THE PHYSICIANS AND HOSPITALS OF ENGLISH MONTREAL

English Montreal

The purpose in limiting this study to the physicians and hospitals of English Montreal¹ is twofold. First, it seems a valid procedure to isolate and consider alone the English-speaking medical community because a real separation exists between the official language groups (French and English) in the City's medical profession. There is no widespread interpenetration but rather a social separation based upon language, in medical schools, hospitals, and physicians' office locations.

There is a French-language (French) medical school at l'Université de Montréal and an English-language (English) school at McGill University. Until 1965 medical-school graduates of the former were not allowed to intern at an English hospital.² Few graduates of McGill are presumed to have interned at French hospitals because of the generally poor knowledge of French on the part of English Montrealers.

¹"Montreal" in this study consists of "Metropolitan Montreal" as defined in, Canada, DBS, 1961 Census of Canada, Population and Housing Characteristics by Census Tracts--Montreal, Bulletin CT--4 (28-8-1963). See Appendix E Map 1 which shows metropolitan Montreal and its communities.

²Interview 3.

The hospitals in Montreal, with the exception noted below,¹ are controlled by boards of management, or owned by proprietors whose majority membership is of one of the two language groups. The hospitals carry on their official business in one rather than both languages. Attending physicians at the two kinds of hospitals are overwhelmingly members of one of the two language groups.²

Physicians' offices are also located according to linguistic similarity between the physician and the neighboring population;³ they are not randomly distributed among the population as would be the case if the medical system were truly bilingual.

¹L'Institut de Réhabilitation which has an English-speaking majority on its board of management, but medical and other professional personnel who are almost all French-Canadian, and which is affiliated with the medical school of l'Université de Montréal.

²In 1964, of the 1,143 attending staff positions in English (British Isles and Jewish) hospitals, 88 (7.7%) were held by French Canadians. Of the 1,049 attending positions in French hospitals, 24 (2.3%) were held by English (British Isles and Jewish) physicians. See Guy Demers, *op. cit.*, p. 81, Tableau 24. In the present study 10.11% of attending positions are held by French Canadians (Appendix B Table B:20). However one hospital (the Bellechasse) that Demers included as French we have included as English for reasons noted in Appendix A Hospitals section, "proprietary hospitals."

³In 1964, 87.5% of French Canadian physicians were located in French Canadian areas of the City (ethnic character of an area defined apparently as 50% of population with the particular origin); and 82.5% of non French-Canadian physicians were located in non French-Canadian areas--88.5% of British Isles physicians, 84.0% of Jewish and 69.0% of other ethnic origins. The present study shows that 13.08% of English Montreal physicians are located in areas of the City where 50.0% or more of the population are French Canadian (French West, North/East Island, Ile Jésus and Environs) (10.60% in the overwhelmingly French North/East Island and Ile Jésus). See Appendix B Table B:23 and Appendix E Table E:2.

This separation between the two systems is generally recognized:

Montreal has two full medical systems, one French in language and the other English, that have reached a high degree of autonomy from one another.

.....
 This does not mean that clients do not cross the language barrier. It indicates only that the two language groups have developed similar institutions in parallel, medical schools and hospitals, which are of either English or French language.¹

The medical profession reflects the equally real separation between the French and English speaking communities of the city:

La séparation entre les Français et les Anglais est très marquée dans le domaine institutionnel. Chaque groupe occupe un territoire bien délimité et possède une gamme complète d'institutions économiques et sociales. Et cette séparation est aussi très marquée dans le domaine des institutions médicales. Chaque groupe possède son université et un réseau bien développé d'hospitaux.²

This fact is acknowledged among sociologists. It was probably first examined by Everett C. Hughes at McGill University in the late 1930's and supported by other students.³ It continues to

¹Jacques Brazeau, "The Practice of Medicine in Montreal," Canadian Society: Sociological Perspectives, ed. Bernard R. Blishen et al. (Toronto: MacMillan of Canada, 1964), p. 217. See also Guy Demers, op. cit., p. 24; Alton Goldbloom, Small Patients: The Autobiography of a Children's Doctor (Toronto: Longmans, Green and Co., 1959), p. 195; and Stanley Lieberman, "Bilingualism in Montreal: A Demographic Analysis," AJS, LXXL (July, 1965), pp. 10-25.

²Demers, op. cit., pp. xiii-xiv.

³See Everett C. Hughes, French Canada in Transition (Chicago: The University of Chicago Press, 1943); Stuart M. Jamieson, "French and English in the Institutional Structure of Montreal: A Study of the Social and Economic Division of Labor" (unpublished M.A. thesis, McGill University, 1938); L. C. Rennie, "The Ethnic Division of Labour in Montreal" (unpublished M.A. thesis, McGill University, 1953); and Aileen Ross, "The French and English Social Elites of Montreal" (unpublished M.A. thesis, McGill University, 1941).

be the accepted description of Montreal in the writings of contemporary French-Canadian sociologists.¹ Perhaps the pressures and trends are away from linguistic segregation, however.²

It should be pointed out that at the level of formal control of the medical system there are single organizations to serve the needs of both language groups within the profession.³

Finally as regards services provided to patients, many English-speaking physicians seem to have sizable French-speaking clienteles,⁴ and all English hospitals take French patients.⁵

The second reason for limiting the study to English Montreal is to keep it within manageable proportions by excluding

¹See the following articles in Marcel Rioux and Yves Martin (eds.), French Canadian Society, Vol. 1 (Toronto: The Carleton Library No. 18, McClelland and Stewart Ltd., 1964): E. Jacques Brazeau, "Language Differences and Occupational Experience," pp. 296-307; J. Brazeau, "Quebec's Emerging Middle Class," pp. 319-327; and Jacques Dofny and Marcel Rioux, "Social Class in French Canada," pp. 307-318.

²This at least is the author's impression. How soon major changes may come is uncertain, however. See Nathan Keyfitz, "Foreward: French Canada Still in Transition," in Everett C. Hughes, French Canada in Transition (1st Phoenix Books edition; Chicago: The University of Chicago Press, 1963), pp. v-vii.

³There is only one Quebec College, Quebec Medical Association, Federation of Medical Specialists of the Province of Quebec, Federation of General Practitioners of the Province of Quebec, and Quebec Hospital Association.

⁴Interviews 1, 3, 9, 10, 16 and 23.

⁵The Royal Victoria in 1962 reported 12% of its patients were French Canadians; St. Mary's reported 15% of its patients French Canadian in 1966. See Royal Victoria Hospital, Annual Report, 1962, and St. Mary's Hospital Building Fund, 1967 (pamphlet published by the hospital, 1967). Presumably at the English-hospital level there is ethnic/religious crossover among English patients, also. The Jewish General, for example, reported 18% of its patients Roman Catholic and 39% non-Hebrew in religion in 1965. See Jewish General Hospital, Annual Report, 1965.

the variable of differing linguistic and cultural systems between the English and French speaking. There appear to be quite important differences in access, status, privileges and duties between attending physicians at French and English hospitals, and in attitudes towards medicine between French and English Canadians in Quebec.¹

English-Montreal Physicians

"Physicians" are persons licensed to practice medicine, surgery or obstetrics by the College of Physicians and Surgeons of the Province of Quebec.² Excluded are interns,³ residents and fellows,⁴ and retired physicians.⁵ This study is a census

¹Brazeau, loc. cit., pp. 203-18, and Demers, loc. cit., p. 57, note 1; and Agnes Ferencz, loc. cit. It appears more difficult at a French than at an English hospital to gain attending affiliation. Thus in 1964 there were 5.97 attending positions (médecins réguliers) for every 100 French-hospital beds compared to 13.03 for 100 English-hospital beds. Derived from Demers, loc. cit., p. 81 Tableau 24 and p. 138 Appendice G-1. French physicians held 1.19 attending positions, British-Isles-origin physicians 1.70 and Jewish physicians 1.50. Ibid., p. 141 Appendice G-4.

²Some functions of the Quebec College are discussed in Appendix A Physicians section. "Physicians" excludes dentists. It also excludes other health practitioners, such as osteopaths and chiropractors, who may apply the term "doctor" to themselves. These health practitioners are not governed by the Quebec College.

³Medical school graduates undergoing the period of training (of at least 12 months duration and usually hospital-based) required before they may set up a private practice. There were 211 interns attached to English Montreal hospitals in the year July 1966 to July 1967. Information from Quebec College.

⁴Physicians whose main professional activity is doing post-graduate and post-internship training in a hospital, research center or university, usually prior to writing exams in order to become certificated in a medical specialty. Except for a few (27) with special licenses, they are not allowed to practise outside of the hospitals of their residency. There were approximately 791 residents and 175 fellows attached to English Montreal hospitals in 1966-1967. "Approximately" because of uncertain name duplication in the lists. Information from Quebec College.

⁵Licensed physicians who indicated to the Quebec College (see the questionnaire, Appendix F Item 2) that they were "retired" as their main professional activity.

of all physicians (as defined above) with their main office in metropolitan Montreal,¹ who have, either English as their preferred language (are "English speaking"),² or both French as their preferred language and attending-physician³ affiliation at an English-Montreal hospital.⁴

Statistical Data on English-Montreal Physicians

The Quebec College has carried out a program of detailed data collection on its physicians since 1964.⁵ Some of the items do not change and the physician is asked this information at time of license granting. Items that may change are specialty certification--gathered from Quebec College or Royal College lists--and office address, professional activities, and sources and mode of professional remuneration. The latter items are

¹The question of physicians listed as "attending" at English-Montreal hospitals, and who have their main office outside Montreal, who are retired or who could not be traced, is discussed in Appendix F Item 1.

²"Preferred language": physicians are asked by the Quebec College whether they wish to receive its communications in English or French.

³This study focuses upon attending physicians. Other types of medical staff--unaffiliated, partial affiliation only and consulting only--are considered, however. These staff types are discussed in Appendix A Hospitals section.

⁴Excluded, therefore, from the population studied are all physicians with French preferred language who have no attending affiliation at an English Montreal hospital. They are assumed to be members of the French-Montreal medical system. The question whether unaffiliated English physicians perhaps have attending affiliation at a French hospital is discussed in Appendix A Hospitals section, "unaffiliated physicians."

⁵A list of the information retained on each physician is shown in Appendix F Item 3. Physicians' "ethnic origins"--important in Chapter III--are discussed in Appendix A Physicians section.

gathered by annual questionnaire.¹ A run of questionnaire response indicated that all 1,414 physicians in the study answered the 1966-1967 questionnaire.²

The Quebec College data are retained on magnetic tape which was generously made available to be copied for this study.³

The author secured data on physicians' hospital affiliations from English Montreal hospitals. This information was coded and key-punched and the Quebec College's tape-copy was updated to contain each physician's hospital affiliations of all types. Programming and computer runs were done at McGill's Computing Center. Since the data represent a census rather than sample of the population studied, no tests of significance are included with the statistics.

English-Montreal Hospitals

This study focuses upon the hospitals located in metropolitan Montreal⁴ whose control is in the hands of English

¹A copy of the 1966-1967 questionnaire is shown in Appendix F Item 2. Physicians licensed after the questionnaire was sent out in May 1967 were asked the same questions at time of license granting. We should note the time conflict between the activities and income data which relate to mid 1966 (for most physicians) and the hospital affiliation data which relate to early 1967. This reflects upon the data in Appendix B Tables B:9, B:18 and B:22 and Appendix G Tables G:4 to G:8. Since the tape was continually updated and since physicians presumably notify their College of address changes, the address data are presumed up-to-date to April 1967.

²The general Montreal response rate was 95%.

³Updated to April 1967.

⁴The location and type of English hospitals is shown in Appendix E Maps 3, 4 and 5.

speaking Montrealers.¹ In the case of the voluntary general and special hospitals² there is agreement as to which are French and which English.³ There could be some discussion about the classification of proprietary hospitals.⁴ We have included those owned by English-speaking Montrealers. We have also included the two federal public hospitals.⁵ This classification is not meant to imply that the hospitals serve only English Montrealers. It is meant to reflect upon the ownership and control of medical facilities.

Data on English-Montreal Hospitals

Data were secured through a short questionnaire sent to the chief administrators and answered by all hospitals in the study.⁶ This yielded lists of medical staff by type, annual

¹Excluding six proprietary chronic hospitals, presumed marginal to careers of the physicians studied. Since, of the two official languages, more Indians at Caughnawaga use English than French, the small general hospital owned by the Indian Band might have been included. However, it was omitted for the same reasons noted above. These hospitals are listed in Appendix B Table B:1.

²The term "hospital" and the various types of hospitals are explained in Appendix A Hospitals section. Our use of voluntary, proprietary and public is discussed there.

³No physician interviewed disagreed with our classification. It agrees with that of Demers except that we included his "Jewish" hospitals with the English. See Demers, *op. cit.*, pp. 132-36.

⁴See Appendix A Hospitals section where this is discussed.

⁵As bilingual organizations they are as much English as French. Additionally, although the medical superintendent in each hospital is a French Canadian, the majority of attending physicians at each hospital has English preferred language. The two hospitals are affiliated with McGill but no longer with l'Université de Montréal.

⁶And by six of the seven excluded English-speaking hospitals; and four French hospitals (sent French questionnaires) thought to have quite a few English attending physicians.

reports for 1965, and discussion of the "open" or "closed" nature of the hospitals. Additional data were secured through interviews and conversations with administrators and medical staff at several hospitals and with officials of McGill University's Faculty of Medicine. Data were also taken from published sources indicated in table notes in Appendix B.

Interviews

Interviews, lasting from 30 minutes to 2 hours, were held with 20 physicians and 5 non-physicians working in the medical area.¹ They explored the significance of hospital affiliation in the physicians' careers, and aimed to provide the author with an accurate picture of medical practice in Montreal.

The following chapter explores the ethnic/religious and class segmentation and stratification of English hospitals, and attempts to set up a system of hospital categories that reflects prestige differentials among hospitals.

¹Appendix F Item 5 indicates the hospitals represented by persons interviewed.

CHAPTER III

STATUS CHARACTERISTICS OF ENGLISH- HOSPITAL CATEGORIES

This chapter will first set up a classification of English-Montreal hospitals, and second examine in detail characteristics that indicate the ethnic, religious and class identifications of hospitals within the different categories. It is the initial part of a two-fold operation. The present chapter will attempt to ascertain whether hospitals have differing status characteristics that could be significant for physicians' careers. Chapter V will examine whether there are typical career sequences--of birthplace, medical school and hospital affiliation--among physicians affiliated with different hospital categories.

Perhaps it would be ideal to examine each hospital individually.¹ However, this would require historical and sociological knowledge about each institution beyond the scope of the study. We decided instead to make a classification. While this distorts reality somewhat, the hospitals within the proposed categories are sufficiently alike, we argue, to warrant their being considered together. This classification allows us to consider the total hospital system within English

¹In lectures on research methods, Professor Gordon Laing has stressed the value of this approach.

Montreal,¹ rather than just one segment of that system, say the general hospitals. The classification method seems preferable, also, since this is primarily a statistical study, and physicians within categories being numerous, percentages are more meaningful. It will be apparent from tables in this chapter that there are differences among hospitals of the same category, as among hospitals of different categories.'

The hospital is a major setting of the medical practice of physicians. Perhaps as much as 45 per cent of services provided by all physicians--accounting for over 50 per cent of aggregate payments to physicians--are provided within hospitals, for visits, laboratory and diagnostic procedures, deliveries and surgery.²

The hospital, then, ranks with the doctor's office as one of the most important locales of practice:

The successful practice of medicine requires access to a multiplicity of institutions. Of particular importance are the hospital, the clinic, and the established office practice.³

Hospitals are a large community investment in facilities and equipment offered for the use of physicians. The "plant fund" assets of Quebec hospitals, including the value of land, buildings and equipment, are of the order of 525 million dollars.⁴

¹With exclusion of 7 proprietary hospitals as noted in Chapter II.

²Derived from Saskatchewan Medical Care Insurance Commission, Annual Report 1966 (Regina: March, 1967), p. 45, Table 7; this province-wide medical-insurance plan covers virtually all physicians' services.

³Oswald Hall, "The Informal Organization of the Medical Profession," p. 30.

⁴Canada, DBS, Hospital Statistics 1964, Vol. IV: Balance Sheets (Ottawa: Queen's Printer, 1966), p. 34, Table 5.

At hospitals a wide range of complicated and expensive facilities and services are brought within easy reach of the treating, diagnosing, and prescribing powers of physicians: laboratory, X-ray and other diagnostic facilities; a complete inventory of drugs; operating rooms; the services of consulting and other attending physicians; the services of nurses, and of additional professional personnel such as physiotherapists, occupational therapists and social workers:

A hospital is thus a form of capital goods, an extension of the doctor's office, his equipment, the services over which he has control, and also of his skills, to which it is a great advantage to have ready access.¹

The hospital is also a main setting for the establishment and maintenance of those relationships among physicians which are major determinants of a physician's career: personal acceptance among colleagues, obtaining and retaining patients, and gaining positions of power and prestige within the profession.²

The importance of the hospital in physicians' careers has only been increased by recent trends in medical practice:

There has also been a phenomenal increase in the equipment used in diagnosis and treatment of patients. One result has been concentration of the bulky and expensive equipment, of the physicians themselves, and of many other kinds of help into great clinics and hospitals. The patients now come to the equipment and the physician. This, in turn, has brought drastic changes in the physician's relations to his

¹David N. Solomon, "Career Contingencies of Chicago Physicians," p. 74.

²Ibid., pp. 71-135; and Oswald Hall, "The Informal Organization of Medical Practice in an American City," pp. 101-240.

colleagues, his patients, and also makes it necessary for him to deal with many new kinds of medical workers; the contingencies of his career are now, in large part, those of his relations to institutions.¹

The hospitals of a city, apparently, form not a homogeneous set but rather parts of a status system. They differ, it would seem, in ethnic/religious and class characteristics and can be ranked accordingly. These differences reflect the class structure of the community to which they belong.

David N. Solomon examined 54 hospitals in Chicago in great detail and discovered that they form a class structure:

The social system of medicine in Chicago--and, no doubt, in other large urban areas--is not a unified homogeneous whole but, rather, one which reflects the ethnic and class segmentation and stratification of the city. The medical community, like the community as a whole, consists of a set of social worlds which are to a degree separate and discrete.

For medical careers, one of the obviously significant contingencies, or perhaps the obviously significant contingency, is which of these subsystems is to be the arena in which the career will be pursued.²

He found that this class structure is highly relevant to the direction and success of medical careers.³ On the basis of his findings we can expect the English hospitals of Montreal to be likewise part of a system that exhibits ethnic/religious and class differences. In Chapter V we will examine whether physicians are differentially sorted into the various parts of the system. This chapter, then, will test the

¹Everett C. Hughes, "Professions in Transition," Men and Their Work, p. 131.

²"Ethnic and Class Differences among Hospitals as Contingencies in Medical Careers," p. 469 and p. 471.

³Solomon, "Career Contingencies of Chicago Physicians," pp. 49-135.

hypothesis that the hospitals studied are not a homogeneous whole but, rather, show marked ethnic/religious segregation, and class stratification.

Methodology

On the basis of Solomon's findings concerning Chicago hospitals, and data on English hospitals gathered from interviews with their physicians and annual reports of the hospitals, we have made a preliminary and somewhat impressionistic classification of English hospitals.¹

For hospitals in each category, data are presented on sponsorship, formal approval, size, expenditures and endowment funds, and certain characteristics of their attending physicians--ethnic origin, specialization, activity, and office location.

The purpose in presenting data on a hospital's physicians is to gauge the ethnic/religious and class character of the hospital on the basis of the characteristics of its physicians. Ideally data should be examined for the three major kinds of persons concerned with a hospital--sponsors, professional personnel, and patients--in order to "place" it within the community. However, this information is not available. And, in any case, using physicians to rank hospitals appears to be a valid procedure in view of the all-important role they play, providing and controlling the services for

¹See Appendix B, Tables B:2 and B:11 for the categories and the hospitals included. Table B:1 shows the full names of the hospitals.

which hospitals exist.¹

Two main types of hospitals are distinguished at first--general hospitals² and special hospitals²--since each has quite different medical purposes which would be expected to influence the institution's prestige. The general hospitals are a more homogeneous type in medical purpose: they treat a wide range of acute conditions. The acute special hospitals³ each have a different purpose. The chronic² and convalescent² special hospitals provide extended care for non-acute conditions.

Starting with these two main categories, sub-categories are made on the basis of, (1) sponsorship--voluntary, proprietary and public, (2) ethnic/religious affiliation--Protestant, Jewish, Catholic and (3) degree of affiliation with McGill University's Faculty of Medicine.

General Hospitals

Classification of Hospitals

A preliminary and ad hoc classification of the hospitals serves as a basis for examination of data on the ethnic and class characteristics of individual hospitals. This classification, with data on hospital sponsorship and establishment

¹Ultimately, of course, control of the voluntary hospital is in the hands of the lay board of management; see F. H. Zuck, "The Hospital Trustee and the Medical Staff," The Medical Staff in the Modern Hospital, ed. C. Wesley Eisele (New York: McGraw-Hill Book Co., 1967).

²This term is explained in Appendix A, Hospitals section.

³Sometimes called "active-treatment" hospitals.

date, is presented in Appendix B, Table B:2.¹ The criteria of classification yield a five-category classification of voluntary hospitals. Categories G2, G3, and G7² contain only one hospital each. These three hospitals have unique characteristics that demand their separate treatment: two are the only Jewish and Catholic general hospitals, and one, the federal hospital, the only general hospital restricted to a specific population of patients.

We will argue throughout this general-hospital section that the voluntary hospitals (G1 to G5) have greater status and prestige than the proprietary (G6). We will also support that, among the voluntary hospitals, the major teaching hospitals (G1) rank higher than the partial teaching (G2, G3 and G4), which in turn rank higher than the non-teaching (G5). While the Jewish (G2) and Catholic (G3) hospitals--the former ahead of the latter--ranking high among the partial teaching, both have whatever drawbacks accrue from identification with a subordinate group of English Montreal. The public hospital's status is ambiguous, we will argue.

The Sponsors of Hospitals

The Voluntary Hospitals

The eight hospitals of categories G1 to G5 are all voluntary, non-profit institutions with boards of management drawn from members of the community who have at least medium

¹Unless otherwise noted, all tables referred to in this chapter are presented in Appendix B.

²Hospital categories are numbered in Tables B:2 to B:10, and are referred to in the text either by their category number or by the short-hand description presented as a note to Table B:2.

socio-economic status and who agree to serve voluntarily, that is, without remuneration. They all share, therefore, in the prestige that accrues to philanthropic institutions, and as a class, have higher prestige than the proprietary or public hospitals:

Every institution to some extent shares the character of its sponsors. The philanthropic patron is a person with prestige, and hospitals with this type of sponsorship enjoy more prestige than do others.¹

The boards of management of the hospitals of categories G1, G4 and G5 are each drawn, in majority, from the Protestant community of English and Scottish ethnic origin. This is the "charter group" of English Montreal, which has the élite position in the community associated with such a group.² Except for one hospital of G5, these are also the longest established of the general hospitals--four of the six prior to 1895.

However, some of these six hospitals have more prestige than others because of their other characteristics and we can surmise that the members of the boards of categories

¹Solomon, "Ethnic and Class Differences among Hospitals as Contingencies in Medical Careers," p. 465. "We realize it is good public relations to help in this sort of thing, and the high executives in large corporations are all in philanthropy today for that reason," quoted in Aileen D. Ross, "Organized Philanthropy in an Urban Community," CJEPS, XVIII (November, 1952), p. 482. "Organized philanthropy across the entire nation is governed by the corporate elite, honorifically if not actually. The boards of charitable organizations . . . and hospitals are almost exclusively the preserve of the corporate elite." John Porter, The Vertical Mosaic: An Analysis of Social Class and Power in Canada (University of Toronto Press, 1965), p. 300.

²Porter, ibid., pp. 60-61, passim.

G4 and G5 hospitals do not have the same status in the community as do the members of G1 hospitals:

Trustees are usually chosen from among the more prominent members of the community . . . [who] have attained high status in business or the professions. . . . The strategic position of a prospective board member in the community at large is generally given first consideration.¹

The Jewish hospital (G2) has directors drawn almost entirely from the Jewish community, and the same is true of the Catholic hospital (G3). More recently established--1934 and 1924 respectively--both these hospitals would reflect the status of their particular communities within English Montreal. The Jewish community is made up to a large extent of immigrants and of comparatively recent arrivals.² A sizeable English-Catholic community has probably been established longer in Montreal, but its present number includes many

¹ Temple Burling et al., The Give and Take in Hospitals (New York: G. P. Putnam's Sons, 1956), p. 40. "As with economic enterprise, there is a capital market available for philanthropic enterprise. In many respects both markets are governed by the same men. When, for example, members of Montreal's corporate elite who were also governors of the Royal Victoria Hospital decided that modernization and expansion of the hospital were necessary, one of their members, Mr. Harold Crabtree, was chairman of a campaign that raised \$7 million." Porter, op. cit., p. 303.

² For example, 40 per cent of Jewish-origin residents of Montreal were born abroad, compared with 21 per cent of British-Isles-origin residents; the Jewish-origin population of Montreal increased from 6,962 in 1901 to 71,403 in 1951, while the British-Isles population increased from 121,585 to 293,147 in the same period. See Canada, DBS, 1961 Census of Canada, Population: Birthplace and Citizenship by Ethnic Groups, Bulletin 1.3--9 (Ottawa: Queen's Printer, 1964), pp. 117-22; and l'Abbé Norbert Lacoste, Les Caractéristiques Sociales de la Population du Grand Montréal (l'Université de Montréal, 1958), p. 77.

recent arrivals.¹

Because they appeared relatively late upon the community scene, and came from less-affluent places like Ireland and the countries of Eastern Europe, both Jews and English-Catholics share the status of "subordinate,"² disadvantaged, groups within the charter-group's community. This is perhaps modified somewhat for the Catholics by their sharing a common religious creed with the charter group.³

The Proprietary Hospitals

The five privately-owned hospitals of category G6 are business enterprises. Three were established after 1957.

Unlike the non-profit voluntary hospitals their proprietors

¹English Catholics (English-speaking) are not given in the Census. The author has estimated their number in Metropolitan Montreal at 262,000. This includes 126,668 known Catholics of British Isles origin. Of the ethnic groups represented in the 135,332 other English Catholics, perhaps as many as 60% were born outside of Canada. Figures derived from Canada, DBS, 1961 Census of Canada, Population: Birth-place and Citizenship by Ethnic Groups, pp. 117-22; idem, Population: Language by Ethnic Groups, Bulletin 1.3--10 (Ottawa: Queen's Printer, 1963), pp. 123--3; idem, Population: Religion by Ethnic Groups, Bulletin 1.3--8 (Ottawa: Queen's Printer, 1964), pp. 113-14.

²W. Lloyd Warner and Leo Srole, The Social System of American Ethnic Groups (New Haven: Yale University Press, 1945), p. 288. "Ethnic groups of neither British nor French origin, which made up about one-fifth of the general population were hardly represented at all [in the economic elite]. There were six Jews (.78 per cent of the sample as opposed to 1.4 per cent of the general population) who were associated with either the liquor industry or two of the smaller dominant corporations." While Catholics formed about 10% of the economic elite, if we separate out French Canadians, English Catholics formed 3.8%. Porter, op. cit., p. 286. English (non-French) Catholics were 15.9% and all Catholics 45.2% of the Canadian population in the 1961 Census.

³A higher proportion of Catholic-hospital than Jewish-hospital physicians have attending status at Protestant hospitals. See Chapter IV.

may retain any profits on the hospitals' operations.¹ Their status as commercial enterprises, in comparison with philanthropic institutions, would detract from their prestige in the community. In addition, four of these hospitals are owned by physicians, and at the fifth one of the shareholders is a physician.² This tends to reinforce their commercial image:

Since doctors' hospitals are likely to be regarded as commercial enterprises, they are generally of low prestige.³

The Public Hospital

It is difficult to place the category G7 hospital within an ethnic/religious and class continuum. Its government ownership, however, implies salaried practice and assignment of patients, both factors traditionally held in low esteem within the medical profession. It is not, in any case, an important locale of private practice.

Formal Approval of Hospitals

Data on accreditation, teaching-hospital status, and nursing-school and psychiatric-unit facilities are presented in Table B:3.

Accreditation

The voluntary general hospitals are all accredited with one exception, a hospital of category G5.⁴ Only two of

¹Physicians and administrators associated with these hospitals report profit margins are very slim under present government regulation of charges. Interviews 22 and 23.

²Interviews 12, 18, 22, 23 and 24.

³Solomon, loc. cit., p. 465.

⁴Perhaps because it only opened in April 1965.

the five proprietary hospitals are accredited. The public hospital has accreditation.

Teaching Hospitals

Being recognized as a teaching hospital¹ is one of the major determinants of a hospital's prestige within the medical profession and the general community:

General hospitals with university affiliation provide the positions of greatest prestige and power to professionals. Their top men play an important role in the formulation and direction of policies in professional associations. They seem to form a special group within the profession. . . . This concept [Oswald Hall's "inner fraternity"] seems to apply to the main functionalities of the university hospitals for acute diseases.²

The two G1 hospitals are the major teaching hospitals of English Montreal, both affiliated with the Faculty of Medicine of McGill University. Although not considered a "teaching hospital," the Jewish General has begun a small amount of approved undergraduate teaching in psychiatry. The federal hospital participates on a relatively limited scale in the undergraduate teaching of medical students.

It is important to note that attending-staff physicians of the two major teaching-hospitals are joint appointments of the hospital and the Faculty of Medicine.³

¹See Appendix A for an explanation of this term.

²Jacques Brazeau, "The Practice of Medicine in Montreal," Canadian Society: Sociological Perspectives, ed. Bernard R. Blishen et al. (Toronto: Macmillan of Canada, 1964), p. 217. Parsons has emphasized the honorific aspect of appointments to teaching posts in medical schools, and this distinction is also accorded to "teaching hospitals." See Talcott Parsons, "The Professions and Social Structure," Essays in Sociological Theory Pure and Applied (Glencoe, Ill.: Free Press, 1949), p. 195.

³Interviews 7 and 20.

A condition of appointment is the physician's agreement to participate in the hospital's undergraduate and graduate teaching program.

The hospitals of categories G3, G4 and G5 are non-teaching, and the same is true of the proprietary hospitals (G6).

Approved Nursing Schools

A further indication of the status of a hospital is its approval as a school of nursing. This adds to a hospital's renown; increases the number of professional personnel at the hospital; and involves its physicians in another "professional"¹ activity--the instruction of nurses.

Nursing schools are found at the major teaching hospitals, the Jewish and Catholic hospitals, and at the largest of category G4 hospitals. None of the other hospitals have schools of nursing.

Psychiatric Units

The presence of a unit for the in-patient care of psychiatric patients is an indication of a hospital's higher status, since it allows staff physicians to admit their psychiatric patients to the preferred general-hospital milieu, where the emphasis is on active treatment. They are less obliged to send patients to the large community mental-hospital with its more restricted services and custodial-type care.

¹A. M. Carr-Saunders, and P. A. Wilson, The Professions (Oxford: Clarendon Press, 1933), pp. 284-318.

Only the major-teaching, the Jewish and the public hospitals, have psychiatric units.

Association with McGill University

Data on association with McGill and approval for internship and residency are presented in Table B:4.

Another degree of affiliation with McGill's Faculty of Medicine is "association." This means certain departments of a hospital are approved by the Faculty for graduate training of physicians proceeding to an advanced degree from McGill (Diploma, M.Sc., or Ph.D.), or taking a residency program directed by the Faculty.

This approval creates a "teaching" hospital in the broad sense and attests to the adequacy of facilities at that institution:

Les hôpitaux enseignants sont en effet les hôpitaux les mieux cotés, tant du point de vue de leur capacité, des moyens matériels et de l'équipement technique dont ils disposent, que du point du vue de la compétence reconnue des médecins qui y pratiquent.¹

The teaching hospitals, of course, have this approval, as does the public hospital. In addition, the Jewish, the Catholic, and the hospitals of category G4 are "associated" with McGill and may be considered in some sense as "teaching" or "partial teaching" hospitals.

Approval for Internship

The six hospitals of categories G1, G2, G3, and G4 are approved for the training of junior interns by both the

¹Guy Demers, op. cit., pp. 75-76.

Quebec College and the Canadian Medical Association. The largest hospital of Group G5 is approved but by the Quebec College only. The public hospital is not approved since it has no departments of obstetrics and paediatrics.

Since approval "may mean only that a hospital has attained the minimum standards, . . . lack of approval may be of greater significance."¹ None of the proprietary hospitals are approved for internship training. This may be associated also with their sometimes limited number of clinical departments.

Approval for Residency

Since residents--and interns--provide "a very great deal of the total patient care offered by the hospital,"² approval for residency attests to "adequate facilities"³ in the hospital by allowing it to attract a number of well-qualified medical graduates.

The six hospitals of categories G1, G2, G3, G4, and the public hospital are approved by both the Quebec College and the Royal College for residency training. The larger hospital of G5 and the largest proprietary hospital are approved by the Quebec College only. The smaller hospital of G5 and the other proprietary hospitals are not approved.

¹Solomon, loc. cit., p. 467.

²Burling et al., op. cit., p. 77.

³Oswald Hall has emphasized "adequate facilities" as a correlate of high status among hospitals. See "The Stages of a Medical Career," pp. 329-33.

Table B:5 presents some qualitative differences among the hospitals approved for residency. It will be noted that the major teaching hospitals have the greatest number of residents and fellows on staff; are approved for residency training in the largest number of specialties; and offer two and three year training in more specialties. Category G2, the Jewish hospital, ranks second according to these indicators, and the Catholic hospital third. One hospital of G4 ranks above the only approved hospital of G5, while the other ranks well below it in number of residents.¹ However, the G5 hospital is not approved by the Royal College.

In category G6, the only approved proprietary hospital is the most limited in its residency program.

The public hospital has a large number of residents, but it offers only one year training in the 13 specialties for which it is approved by the Quebec College.

Size, Expenditures and Endowments

The data considered in this section are presented in Table B:6.

A hospital's size, unit expenditures and endowments are all indicators of the institution's community prestige and adequacy of facilities. Size "itself is not necessarily a status characteristic, but does give some indication of the cost of plant and equipment, which to some extent is relevant."² Expenditures per bed are an indicator, however crude,

¹Presumably due to its relatively small size.

²Solomon, "Career Contingencies of Chicago Physicians," p. 30.

of the relative range and quality of medical facilities available for patient care. Endowment funds certainly reflect a hospital's value in the eyes of important and wealthy members of the community--its prestige and status, therefore. Under a hospital-insurance system such as Quebec's, where hospitals' operating expenses are paid by the government and private and semi-private patients, income from endowments is frequently devoted to medical research, which is another indicator of status:

Research brings prestige to the hospital, not only in the eyes of patients, but in the attitudes of the larger community.¹

The major teaching hospitals are the largest in number of beds, have the highest unit expenditures and the wealthiest endowment funds. The Jewish hospital is considerably smaller than these, but ranks with them in unit expenditures, and has larger endowments than any of the other hospitals. Compared to the latter, the Catholic hospital has somewhat fewer beds, has lower unit expenditures, and is practically devoid of endowments. Categories G4 and G5 are close in hospital size, but unit expenditures and endowments are higher in the former.

With one exception, the proprietary hospitals (G6) have considerably fewer beds, and lower unit expenditures than the voluntary. In keeping with their commercial status, none are endowed.

¹Burling et al., op. cit., p. 89.

The public hospital is among the largest, but has low unit expenditures¹ and, as a government-owned institution, does not attract endowments.

Characteristics of Physicians

Ethnic Character of Hospital Categories

Just as the ethnic character of a hospital's sponsors gives an indication of the relative position of the hospital within a community's status system, so also does the ethnic character of its major personnel, its physicians.

In Table B:7 we see that English and Scottish physicians tend to predominate in the hospitals associated with the Protestant community--categories G1, G4 and G5--with the greatest concentration occurring in the major teaching hospitals. The Reddy Memorial is an exception. Its relatively low proportion of such physicians, combined with a high proportion of Jewish--higher than in any other of the non-Jewish voluntary general hospitals--and a high proportion of "other non-French"² physicians suggests that this hospital functions

¹Presumably due to the relatively advanced age of its veteran patients, and their longer average stay compared to voluntary general hospitals (22 days compared to 12 days: Canada, DBS, Hospital Statistics, Vol. 1: Hospital Beds, op. cit., p. 80 and p. 102). Both factors detract from a hospital's status in the eyes of some physicians: "It is a chronic hospital, full of leadswingers, people who say, 'look after me.'" Interview 10. "Public institutions, for example, have the largest bed-capacity in the city but are of low prestige, except for certain types of training." Solomon, "Ethnic and Class Differences among Hospitals . . .," p. 467, note 21.

²That is of other than English, Scottish, Jewish or Irish ethnic origin. These physicians number 321 in English Montreal, of whom 180 have East European, 111 have West European, and 30 have other ethnic origins.

to give status to these non-charter ethnic physicians. Whether within their own community or within the charter community, however, is a question for further research.¹

Excluding this exception, the G5 hospitals have fewer English/Scottish physicians than do those of G4 and G1.

The "other non-French" category may be used as an indicator of ethnic heterogeneity among the English/Scottish-hospital physicians. We note that the lowest proportion in this category is in G1, followed by G4 and then G5.²

Sixty-five per cent of the Jewish-hospital physicians are Jewish, since, aside from patient care, it was founded to provide opportunity for hospital-staff membership for Jewish physicians.³

The ethnic split of the Catholic-hospital physicians is 21% Irish, 28% other non-French, and 35% English and Scottish. This matches the known Catholic majority among physicians at this hospital, which was also founded to provide for the needs of a specific ethnic/religious community.

The ethnic mix of proprietary-hospital physicians reflects their ownership and purpose. They are all owned by

¹Professor Solomon has suggested that the former is the case, while some of the physicians interviewed suggested the latter. Interviews 10 and 16.

²"Thus immigrants of non-British or non-United States origin got into the economic elite scarcely at all, a conclusion consistent with the relationship between ethnicity and occupation which we saw in Chapter III." Porter, op. cit., p. 287.

³M. B. Etziony, History of the Montreal Clinical Society (Published on fiftieth anniversary of the Montreal Clinical Society, Montreal, 1963).

members of the Jewish community¹ and thus have a relatively high proportion of Jewish physicians. One of their purposes is to provide beds for physicians who do not have access to voluntary-hospital beds in either of the two major language communities. Therefore they are characterized by high proportions of other non-French and French physicians. Their relation to the charter community is reflected in the low proportion of English and Scottish physicians.

Of the 16 public-hospital² physicians, 44% are of French origin, although 31% are of English, Scottish or Irish origin, and 13% are Jewish.

The ethnic composition of physicians who have attending-staff status may be contrasted, in Table B:20, with that of physicians with no staff membership, or with some other type. Apart from one proprietary hospital, in G6, the greatest concentration of other non-French physicians--the heterogeneous ethnic category--occurs among the "unaffiliated" category, those with no formal hospital affiliation of any type. A relatively low proportion of English/Scottish physicians is found among this category, compared to the voluntary Protestant hospitals (G1, G4, G5, S1, S2, S3).

¹Interviews 22 and 23.

²We should note that this 700 bed hospital is served by 130 "consultants," of whom 116 are English-Montreal physicians and 92 are attending physicians at English voluntary hospitals (70 at G1 or S1). These physicians perform many of the functions of "attending" staff at this hospital: interviews 5, 15 and 17.

Specialization and Activity

Data on specialization and selected medical activities are presented in Tables B:8 and B:9.

Having a specialty certificate facilitates a physician's limiting his practice to a specialized field of medicine, and adds to his prestige:

Although the medical specialties differ in prestige and members of any specialty differ among themselves, specialty practice is in general both more remunerative and more rewarding in prestige than is general practice. Moreover certified specialists have greater prestige.¹

Holding specialist qualification through Royal College fellowship also carries prestige, since fellowship involves training that emphasizes research and teaching and examinations are generally stiffer.² Having Royal College certification or fellowship implies unrestricted mobility across Canada since the other Canadian Colleges of Physicians and Surgeons do not accord recognition to Quebec certification only.³ On the other hand having certification only by the Royal College implies some limitation upon specialist recognition within Quebec since the Quebec College does not accord

¹Solomon, "Ethnic and Class Differences among Hospitals . . .," p. 468. See also Jacques Brazeau, op. cit., p. 209. Average payments to general practitioners under Saskatchewan medical insurance in 1966 were approximately \$26,500, and to specialists, \$33,600. Saskatchewan Medical Care Insurance Commission, op. cit., derived from pp. 31, 41, and 50.

²"The prestige of the Fellowship ranks high in university and hospital centres in Canada and throughout the British Commonwealth and elsewhere as a hallmark of attainment," The Royal College, Brief to the Royal Commission on Health Services (February, 1962), p. 3.

³Information from the Royal College.

specialist status to physicians who do not hold Quebec certification. These physicians may be able to function quite fully within the English-hospital system, but their mobility within Quebec would be limited.

Holding more than one certificate carries the prestige attached to extensive graduate training and thus reflects upon such physicians.

Consulting-staff status stands for recognition among colleagues and is another addition to the prestige of physicians.

Imparting and advancing theoretical knowledge are both functions of a major profession and marks of a high-level professional career.¹ Taking part in medical education or research, therefore, are other indicators of a physician's prestige.²

Among the Protestant voluntary hospitals, we notice, in Tables B:8 and B:9, category G1 has the highest proportion of specialists (physicians with specialty certification), fellowships and Canadian certifications. Fewer of its specialists have certification by the Quebec college or the Royal College only; and more of its Quebec-certificated specialists have two or more certificates (multi-specialists). More of its physicians have consulting-staff status at an English-Montreal hospital, are engaged in medical teaching and in

¹William J. Goode, "Encroachment, Charlatanism, and the Emerging Profession: Psychology, Sociology, and Medicine," ASR, XXV (December, 1960), 902-26.

²Guy Demers used "mixed practice" involving teaching or research, and treatment activity, as an indicator of the successful career. Demers, op. cit., pp. 55-57.

medical research. G4 and G5 have progressively (G5 ranking after G4) fewer specialists, fellowships and Canadian certifications, and multi-specialists. More of their specialists have certification by one Canadian agency only. Progressively fewer of their physicians are consultants, teachers and, with a partial exception in G5,¹ researchers.

While the Jewish and Catholic hospitals rank with or above category G4 on each of these indicators, the Catholic hospital ranks somewhat higher than the Jewish on all but multi-specialists and researchers, though only on the latter is the difference equal to 5%. The proportion of specialists ranges from 81% to 98% in the voluntary hospitals (G1 to G5).

Over 55% of attending physicians at proprietary hospitals are general practitioners (non-certificated physicians). They rank well below the voluntary hospitals in fellowships (except for one hospital), and Canadian certifications. With the same hospital excepted, they have considerably more one-agency certifications. They have fewer consultants and teachers. Two of the five hospitals have more researchers than category G4; the others have none. While the proportion of specialists is low in this category, the proportion of multi-specialists among the specialists at two of the hospitals is relatively high. This suggests these hospitals act as referral systems for highly qualified specialists, who also perhaps, are the physicians who control them.

¹Since 10 physicians in this category are also attending physicians at G1 hospitals, it is possible that the researchers are the physicians who are on staff in both categories. The question of attending-staff duplication is discussed in the next chapter.

The public hospital's position is ambiguous according to these indicators. It ranks between the voluntary and proprietary hospitals on specialists, fellowships (with one exception) and Canadian certifications; with G4 on one-agency certifications; above G5 on multi-specialists. It ranks above G5 on consultants and teachers; and it ranks below only G1 on researchers.

Specialization and activity data may be compared for major classes of hospital-staff affiliation in Tables B:21 and B:22. Comparing only attending and unaffiliated physicians we have, respectively, 16% and 67% general practitioners; 36% and 5% fellowships; 21% and 54% one-agency certifications; 23% and 0% consultants; 43% and 13% teachers; and 20% and 9% researchers.

Office Location

Sociologists have called attention to the prestige attached to a physician's office location close to the center of a city:

The location of a service near the center of a city suggests a clientele that is at least city-wide. Decentralized establishments, on the other hand, serve a local clientele. Moreover, medical specialists concentrate near the center of a city in what is, for this and perhaps other reasons, an area of practices enjoying great prestige.¹

A concentration of physicians near the city-center implies close technical and referral relationships among them. Hall found the "inner fraternity" to be drawn from among these

¹Solomon, loc. cit., pp. 468-69. See also Jacques Brazeau, "The French Canadian Doctor in Montreal . . .," pp. 7-15; and Guy Demers, op. cit., pp. 57-59.

physicians, that is the group that has most power and influence within the medical system of a community.¹ Solomon found a strong association between office location in the city center and residence location in the areas of high socio-economic status.²

The areas considered in this discussion of office location are illustrated in Maps 2 and 5 in Appendix E.³ It may be noted that West Center and East Center overlap the city-center and extend hardly more than a mile outside.⁴ Eleven of thirty English hospitals are located within a mile of the city-center. East Center is the area of greatest ethnic heterogeneity, while other non-French make up a greater part of the West Center population than they do of any other area except East Center.⁵

Among the Protestant voluntary hospitals, in Table B:10, category G1 has the greatest proportion of physicians with offices at or very close to the city-center (West Center and East Center), followed by G4 and G5 in that order.

¹Oswald Hall, "The Informal Organization of the Medical Profession," pp. 30-44; and "Types of Medical Careers," pp. 248-51.

²Solomon, "Career Contingencies of Chicago Physicians," pp. 34-43.

³These maps should be examined in conjunction with their introductory notes. With Tables E:1 to E:7, relations may be studied among office locations of English-Montreal physicians, population density, and the Montreal population, by ethnic origin, official-language spoken, and statistical area.

⁴Appendix E, Map 5. The "city-center" is discussed in notes to Map 5.

⁵Appendix E, Table E:2.

The G4 physicians are largely concentrated in West City; while a majority of the G5 are in Far West, the "Lakeshore" area.

Compared to other physicians, Jewish-hospital physicians have the greatest concentration in West City, and the second lowest in North/East Island, Ile Jésus and Environs taken together. Catholic hospital physicians are somewhat less concentrated in West City, somewhat more in West Center, and North/East Island, Ile Jésus and Environs together.

Proprietary-hospital physicians are heavily concentrated in the predominantly-French North/East Island, although one hospital has heavy concentrations in West City, East Center and West Center. This is also the hospital with the greatest proportion of other non-French physicians. The highest proportion of other non-French among the general population occurs in East Center, we may note.¹

The public-hospital physicians are largely in West City.²

While centralization/decentralization of practice correlates with the other indicators of prestige that we have presented, it may also be observed that office location is associated with hospital-location.³ Thus the decentralized hospitals have physicians with decentralized practices and vice versa.

¹Ibid.

²For a few physicians who practice mainly within the public hospital, "office address" may actually be home or second-office address. They did not report the hospital as their main address.

³See Appendix E, Maps 2 to 5.

Office locations of physicians by major classes of hospital affiliation are shown in Table B:23. If we compare only attending and unaffiliated physicians we note that fewer of the former are in North/East Island, 9% and 22% respectively; fewer in Ile Jésus and Environs, 2% and 6%; fewer in East Center, 3% and 10%; more in West Center, 37% and 24%; and more in West Island, 48% and 38%.

The data we have presented in tables B:1 to B:10 support the hypothesis we set out to verify, that there are marked and important ethnic/religious and class differences among hospitals, general hospitals in this case; and that the categories of hospitals we have devised reflect these differences. The voluntary hospitals rank consistently above the proprietary, while the public hospital, involving only few physicians, has an ambiguous position within the hospital system. Among the Protestant voluntary hospitals the categories are ranked in this order, G1, G4, G5. While the Jewish and Catholic hospitals rank either with or above G4, the Jewish ranks somewhat higher than the Catholic on hospital characteristics, the Catholic somewhat higher on physicians characteristics. We suggest that perhaps the most important sociological characteristic of the latter hospitals is their identification with a subordinate ethnic/religious community within English Montreal.

Special Hospitals

Classification of Hospitals

As with general hospitals, an ad hoc classification of the special hospitals serves as a basis for examination of data on the ethnic and class characteristics of individual institutions. This classification, with data on hospital sponsorship and establishment date, is presented in Appendix B, Table B:11. The major sub-groups among special hospitals are "acute hospitals" where active treatment of acute conditions predominates and "chronic and convalescent hospitals"¹ for the long-term care of post-acute conditions.² Much more medical treatment takes place in the former, which would give them greater prestige in the eyes of the medical profession. Also, chronic and convalescent hospitals are not major locales of private practice. Criteria for further classification are ownership, ethnic/religious affiliation, and degree of association with McGill University's Faculty of Medicine.

We will begin this special-hospital section by suggesting that acute hospitals have more prestige than chronic, while the public hospital appears to be on the margin of English-Montreal medical practice. This ranking is supported by the hospital characteristics. However, the hospitals may not be unequivocally ranked from S1 to S3 followed by the

¹Both referred to as chronic hospitals for short.

²For a discussion of the inclusion of the Douglas mental hospital with the acute special see Appendix A, Hospitals section.

chronic, according to their physician characteristics. The only consistent ranking is that between S1 and all the other special hospitals. Acute-special and chronic hospital-affiliations seems to be mainly an adjunct to the careers of many physicians.¹ Thus the relative prestige of acute-special and chronic hospitals only becomes significant for the careers of physicians whose major orbit of practice is a hospital of that category. Again this raises the question of staff duplication which we will examine in the following chapter. Finally we will argue that the main difference between the Christian and Jewish chronic hospitals is their identification with a particular ethnic/religious community.

The Sponsors of Hospitals

The Acute Hospitals

There is no apparent pattern to the establishment dates of acute hospitals, although they were on the whole established later than the voluntary general hospitals. The seven hospitals of categories S1 to S3² are all non-profit institutions with voluntary boards of management. Each board is drawn, in majority, from the Protestant community of English/Scottish ethnic origin. The two hospitals of category S3 are owned by particular movements within that

¹We will see in Chapter IV that 39% of general-hospital physicians have more than one attending-staff affiliation; 71% of acute-special physicians; and 82% of chronic physicians.

²Hospital categories are numbered in Tables B:11 to B:19, and are referred to in the text either by their category number or by the short-hand description presented in a note to Table B:11.

community, one by the Salvation Army, the other by the Shriners--a group of higher-ranking Free Masons.¹ All these hospitals, then, share the status of belonging to the "charter group" community. Differences in status among them are probably due to class differences among their sponsors, and also to their purposes and the differences in prestige accruing to the specialties they feature. Thus the paediatric and neurological specialties probably have more prestige than do the specialties concerned with chest conditions, infectious diseases and mental conditions. This implies a status difference, therefore, between the S1 and S2 hospitals.

The Chronic and Convalescent Hospitals

There is no apparent pattern to establishment dates among the chronic hospitals, although three were established more recently than the acute hospitals and the Jewish were established later than the Christian. With the exception of the one public hospital, all chronic hospitals are non-profit institutions with voluntary boards of management.² Four of the five hospitals of category S4 each have boards of management the majority of whose members are drawn from the Protestant community of English/Scottish origin. One has a Catholic board of management and was founded by Catholics. The Catholic and Protestant hospitals were included together for the sake of simplicity.

¹Montreal Star, October 30, 1967, p. 4.

²The six proprietary chronic and convalescent hospitals of English Montreal have been excluded from the study as mentioned in Chapter 2. Their locations are shown in Appendix E, Map 4.

The three hospitals of category S5 are Jewish in ownership and control. Perhaps there is a distinction in prestige between the Jewish and the Protestant chronic and convalescent hospitals because of the generally higher status attached to positions in British hospitals of Montreal compared to the minority ethnic institutions.¹

The public special-hospital, like the public general-hospital, appears to be on the margin of any status system of English-Montreal hospitals because of the restricted population it exists to serve. However, this mostly-chronic hospital presumably shares the lesser medical prestige of other chronic hospitals.²

Formal Approval of Hospitals

Data on accreditation, teaching-hospital status, and nursing-school and psychiatric-unit facilities are presented in Table B:12.

Accreditation

With exceptions of the Douglas (mental) hospital of category S2, all the acute hospitals are accredited.³

Only two of the chronic and convalescent hospitals are accredited--one British and one Jewish. The federal hospital is accredited.

¹Rosalynd Gold, "Occupational Selection and Adjustment in the Jewish Group in Montreal with Special Reference to the Medical Profession," p. 146.

²Some physicians, however, report on highly original and satisfying careers within both these hospitals, mentioning interesting clinical material in gerontology and parasitology. Interviews 5 and 17.

³The Douglas gained accreditation in 1968, one of only three mental hospitals in Canada to have it. The Globe and Mail (Toronto), February 29, 1968, p. 5.

Teaching Hospitals

The five hospitals of categories S1 and S2 engage in undergraduate teaching of medical students and are considered teaching hospitals by McGill. More teaching is done at S1 and they are more closely associated with McGill. The two hospitals of category S3 are non-teaching.¹

The chronic and convalescent hospitals are non-teaching. Being on staff at such a hospital is presumably less sought after and is accorded less prestige by the profession and the community:

Positions of intermediate advantage are gained more easily, and through a shorter period of supervised training, in departments that are ancillary, in hospitals of small size, and in institutions for the treatment of chronic diseases.²

Nursing School and Psychiatric Unit

Perhaps by definition these facilities are usually not found at special hospitals. The Children's, as a hospital for general conditions among a special category of persons, is an exception and does have a psychiatric unit like the high-prestige general hospitals. The Douglas is a mental hospital and therefore does not have a special psychiatric unit. Practically half the Ste. Anne's hospital is a "psychiatric unit," a mental hospital really. No other special hospitals have psychiatric units; and no special hospitals have schools of nursing.

¹Although the Shriners does provide a small amount of undergraduate training in paediatric surgery to fourth-year medical students. McGill University, Faculty of Medicine 1966-1967, Montreal, p. 39.

²Jacques Brazeau, loc. cit., p. 214.

Association with McGill University

Data on association with McGill and approval for internship and residency are found in Table B:13.

With the exception of one in category S2 all hospitals of categories S1 and S2 are directly associated with McGill University's Faculty of Medicine for the graduate training of physicians proceeding to an advanced degree or studying for specialist certification. The S3 hospitals are not directly associated with McGill.

No chronic and convalescent hospitals have university affiliation.

Approval for Part of Internship

Only two hospitals, one of category S1 and one of S3, are approved by both the Quebec College and the Canadian Medical Association for part of internship. The former takes interns on rotation from four hospitals, the latter from one hospital. One S2 hospital is approved by the Quebec College for part of internship.

Approval for Residency

With the exception of the Alexandra¹ hospital in S2, all acute hospitals are approved for residency training. No chronic or convalescent hospitals are approved, except for the public hospital which functions also as a mental hospital and is approved for training only in psychiatry.

Table B:14 presents some qualitative differences

¹As noted in Table B:6, this hospital is declining in importance due to the decline in incidence of the diseases it treats.

among the hospitals approved for residency. It may be noted that the major teaching hospitals have the most residents, are approved for the greatest number of specialties, and offer the longest training periods.

The other teaching hospitals (S2) have fewer residents and a more restricted training program.

The residency training program in hospitals of S3 and S6 are even more limited.

Size, Expenditures and Endowments

The data considered in this section are presented in Table B:15.

As asserted earlier about general hospitals, expenditures and endowments indicate something of the relative prestige of special hospitals. Size, however, is not as accurate an indicator for special hospitals because of the relation of size to the special purpose of the hospital.¹

The major teaching hospitals have the highest unit expenditures and endowments. The hospitals of categories S2 and S3 are heterogeneous in unit expenditures and unit endowments, and both rank below those of S1.

The high endowments of the Shriners seem to reflect more this movement's ability to draw funds from all over Canada and the United States, rather than a special regard of

¹Thus mental hospitals are uniformly among the largest in Canada, but no one would pretend that their size is correlated with the best facilities or with high prestige. Conversely, the neurological hospital, because of the relatively low incidence of severe neurological problems, is moderately sized but has very high prestige for other reasons.

the English-Montreal community for the hospital.¹

Size is not correlated with expenditures or endowments among the chronic hospitals. Their unit expenditures are uniformly lower than in the voluntary general and most of the acute hospitals. There is little difference in expenditures between the Christian and Jewish hospitals. Unit endowments are high in the chronic hospitals compared to the general hospitals; however they are considerably lower than in the acute special hospitals. Two of the three Christian hospitals with endowments have funds well in excess of endowments at the two Jewish hospitals with such funds.²

The public hospital, the second-largest in English Montreal, has average chronic-hospital expenditures and, as a government institution, is not endowed.

Characteristics of Physicians

We will see in this section that the data on physician characteristics for special hospitals is ambiguous, and does not fully support the class system of special hospitals we have developed in the previous pages. Thus, while we have argued that chronic hospitals rank below the voluntary general and special hospitals, and that among the acute special hospitals there are major prestige differences among S1, S2 and S3 (ranked in that order), the physician data does not fully

¹Montreal Star, October 30, 1967, p. 4.

²Since the Catholic general hospital has very low endowments, the large endowment of the Catholic convalescent hospital suggests that it has perhaps received funds from the Protestant community, and that it is properly classified, therefore, with its chronic hospitals.

support this scheme. We find high-prestige physicians at the relatively lower-prestige acute-special and at the chronic hospitals. For most physicians, we will argue, the chronic hospital is only an adjunct to their practice and not its main institutional orbit. While, for many acute-special physicians, the special hospital appears to share center stage in their professional activity with the general hospital. This raises two issues, (1) the pattern of staff duplication, and (2) whether class differences between special and general hospitals, and among special hospitals may be really significant only for physicians who have affiliation with hospitals of one class. Both issues will be examined in the following chapter.

Ethnic Character of Hospital Categories

English and Scottish physicians in Table B:16 are the predominant ethnic category in all the special hospitals except the Jewish and Catholic chronic. S2 hospitals have greater ethnic heterogeneity than the S1 as we would by now expect. However, the S3 hospitals exceed S1 in their concentration of British-origin physicians. On the other hand the S1 hospitals have a higher proportion of Jewish physicians than we would expect after looking at comparable general hospitals (G1). Certainly there is a greater concentration of Jewish, Irish--and presumably of Catholic religion--and other non-French physicians in S2 than in S3 hospitals. S3 hospitals appear as a special case to which prestige dimensions do not apply clearly. If we then make a comparison between S1 and S2 hospitals only, we see a movement away from

a concentration of British-origin physicians. Except for S3, acute special hospitals have more ethnically heterogeneous staffs than do the voluntary general hospitals.¹

The ethnic origin of chronic-hospital physicians illustrates the community identifications of these institutions. The Christian hospitals (S4) are English and Scottish or, at the Montreal Convalescent, Irish and presumably Catholic. The Jewish hospitals (S5) have a large majority of Jewish physicians.

The public hospital, with only 14 attending physicians, has a high proportion of other non-French physicians; and 50% of its physicians are either French or other non-French.

Specialization and Activity

These characteristics are displayed in Tables B:17 and B:18. One S1 hospital has more specialists than category S2, the other is equal to the lower S2 hospital in this respect. Compared to S2, S1 has proportionately more fellowships, and Canadian certifications. It has fewer one-agency certifications, and, if we ignore the Royal Edward,² somewhat

¹Perhaps this is related to their more recent establishment; perhaps ethnic disadvantages do not count as much in situations where a specialized practice of medicine occurs; and perhaps the disadvantaged ethnics are well represented in those specialties that do not have great prestige in the medical community generally, paediatrics, psychiatry and chest conditions for example. Fourteen per cent of Jewish General physicians are paediatricians, for example, compared to 3% and 1% in the two G1 hospitals.

²The unusually high proportion of multi-specialists at the Royal Edward and Catherine Booth is explained in a note to Table B:17.

more multi-specializations. It has more teachers and researchers.

On these indicators, S3 ranks above S2 and usually with or above S1. Again, according to physician characteristics it is a high-prestige category.

The Christian and Jewish chronic hospitals are fairly similar in terms of the characteristics considered here, although the Jewish physicians rank higher than the physicians at four of the five Christian hospitals taken together, on specialization, fellowships and Canadian certifications, multi-specialists, and researchers; they rank lower on one-agency certifications. The Christian-hospital physicians rank quite higher on the proportion of their physicians who are consultants, an important measure of their prestige in the medical status system.

The chronic hospitals tend to rank above S2 and frequently with S1 on these characteristics. Only in their proportion of teachers do all the chronic hospitals rank below S2.

The public chronic hospital ranks with the lowest on specialists, fellowships, Canadian certifications, one-agency certifications, multi-specialists, and consultants.

Office Location

Again, office locations are associated with hospital locations.¹ However, they are also associated with the relative prestige of hospitals. Thus the major teaching hospitals (S1) have a heavy concentration of physicians within

¹See Appendix E, Maps 2 to 5.

the small area of West Center. Less S2 physicians are located in this area, although the Royal Edward has a high proportion in East Center close to the hospital. Unlike any other general or special hospital the Montreal Children's has at least one or two physicians in each office-location cell.

S3 physicians are more concentrated in West Center than those of S2.¹

Although a plurality of special-hospital physicians are concentrated in West Island, their absence from French West, as for general-hospital physicians, is a notable indication of the linguistic separation of medical practice in Montreal.

As with general-hospital physicians, those at Christian chronic hospitals² are more concentrated in West Center, while Jewish chronic physicians are heavily concentrated in West City.³

A majority of the public-hospital physicians are located in Far West as we would expect.⁴

The data we presented in Tables B:11 to B:19 did not support unequivocally the hypothesis we set out to test in

¹This is because elite general hospital physicians are attached to these hospitals, as discussed in Chapter IV.

²For a few physicians who practice mainly within chronic hospitals, "office address" may actually be home or second-office address.

³Of the two areas of greatest physician concentration in Montreal reported by Guy Demers for 1964, one was in West Center, the other, in West City, comprised the area around the Jewish and Catholic general hospitals. Demers, loc. cit., Appendice D-8. See Appendix E, Introductory Notes.

⁴The qualification noted above for chronic hospitals applies to this hospital as well.

this section, that there are marked and important ethnic/religious and class differences among special hospitals; and that the categories of hospitals we have devised reflect these differences. On virtually all the indicators S1 ranks highest as we would expect. However, while S2 and S3 and the chronic hospitals tend to be ranked in that order according to hospital characteristics (Tables B:11 to B:15), the order is rather upset by the physician characteristics (Tables B:16 to B:19). As we shall see in Chapter IV this is due to staff duplication, and the fact that many elite general-hospital physicians are affiliated with the special hospitals. We suggest here that, while there appear to be class differences among special hospitals, these seem to be related as much to the prestige of the range of illnesses they treat, as to their physicians' characteristics. Apart from the obviously-elite S1 hospitals, the prestige dimensions of special hospitals should be examined, perhaps, for individual institutions rather than for categories. Finally, for our statistical purposes we should take S2 and S3 hospitals as one category, and both types of chronic hospitals as another, and consider the prestige differences among these broader categories as having an important influence only upon the careers of their physicians who do not have affiliation to a higher-level category.

Summary

In this chapter we set out to verify, first for general hospitals and then for special hospitals, the hypothesis that the hospitals of a city are not a homogeneous

whole, but rather exhibit marked and important ethnic/religious and class differences.

For each hospital (where feasible) we examined data on the nature of its sponsorship, on elements of its formal approval--accreditation, undergraduate teaching, nursing school and psychiatric unit facilities, graduate teaching in association with McGill University, approval for internship and residency, size, expenditures and endowments--and on characteristics of its physicians that would define the character of the hospital--ethnic origin, specialization and participation in prestige activities (consulting staff, teaching, medical research), and office locations.

For general hospitals, the data supported our hypothesis and we were able to separate three main prestige-categories--voluntary, proprietary and public hospitals. Voluntary hospitals have the greatest prestige; proprietary the least. The public hospital has ambiguous status characteristics; and is only a major locale of practice for a few physicians. It appears, however, to be an important adjunct to the careers of some elite-hospital physicians; but an adjunct only.

Among the voluntary hospitals we were able to distinguish clearly five sub-classes. At the top are the major teaching hospitals, followed by the partial-teaching hospitals, followed in turn by the non-teaching hospitals. Within the partial-teaching category we distinguished among the Protestant, the Jewish and the Catholic hospitals. The Jewish and Catholic tended to rank with or somewhat above the Protestant.

However, both are closely identified with subordinate ethnic/religious communities within English Montreal. This disadvantage affects each hospital differently. The Jewish ranks above the Catholic on hospital characteristics; the latter above the former on important physician characteristics.

Turning to special hospitals, we found our hypothesis supported by hospital characteristics, but not by physician characteristics. Only the distinction between the major teaching and the other hospitals is especially clear. The presence of high-prestige physicians at many of these other hospitals tends to blur further distinctions. We suggested that a special hospital's prestige may be a significant factor solely in the careers of physicians who have affiliation only within its class.

The low ranking of the public special hospital, however, did fit our hypothetical framework.

In the following chapter we will examine more closely the question of duplicate staff membership. Our main purpose will be to establish meaningful hospital and physician categories in order to examine in Chapter V, the influence of birthplace and medical school in sorting physicians into the hospital class system.

CHAPTER IV

ATTENDING PHYSICIANS: STAFF DUPLICATION

We want to examine in this chapter the extent and meaning of staff¹ duplication and set up rules to control for it. We saw in the last chapter that similarities in physician characteristics between physicians at the lower prestige non-teaching special (S3) and the chronic hospitals (S4 and S5), and physicians at the major teaching general and special hospitals (G1 and S1) may be due to the fact of staff duplication--the staffs of the former hospitals are made up to a large extent of physicians who also are on staff at the elite hospitals. We suggest that, if staff duplication is extensive, our examination, in the next chapter, of the process whereby physicians are sorted into the hospital system will not be meaningful unless we control for it.

Staff Duplication

Appendix C Table C:1 shows that there are 1,447 attending positions in English hospitals for the 1,414 English-Montreal physicians, slightly more than one for each physician.

¹Unless otherwise noted, in this chapter "staff" and "on staff" refer to attending staff; "positions" refers to attending positions; "affiliation" refers to attending-staff affiliation; and "physicians" refers to attending physicians. The short hand hospital-category descriptions shown in Appendix B Tables B:2 and B:11 are used here also.

These positions are held, however, by 1,008 attending physicians--144.6 positions for every 100 physicians. Of attending physicians, 35.7% are on staff at more than one hospital. Attending physicians comprise 71.29% of all English-Montreal physicians, while those without attending-staff affiliation comprise 28.71%.¹

When we consider main hospital types the degree of staff duplication is greater.² Thus Tables C:4 and C:5 show that 38.3% of general hospital physicians and 71.2% of special-hospital³ physicians have more than one hospital affiliation. While the former have 147 positions and the latter 193 positions per 100 physicians.⁴

Thus staff duplication is a factor to be reckoned with. We ought to control for it when we examine, in the next chapter, the influence of birthplace and medical school upon the sorting of physicians into the hospital system described in Chapter III. If we do not we will not be examining, as we want to, typical career sequences in hospital categories, since among the physicians in a given category will be those with

¹This percentage (28.71) is made up of 13.2% with no formal affiliation ("unaffiliated"); 4.7% with partial affiliation only; 9.7% with consulting-staff affiliation only; and 1.1% (16) with both partial and consulting-staff affiliation. The question whether unaffiliated physicians possibly have formal affiliation with a French hospital is discussed in Appendix A, Hospitals section.

²This is arithmetically possible because of the differing mix of physicians.

³For acute-special physicians the figure is 70.5%; for chronic hospitals (excluding the public) it is 82.6%.

⁴For acute-special physicians the figure is 187.6 and for chronic (excluding the public) 226.1 positions per 100 physicians.

affiliation to another category. Since we are implying throughout this study that the prestige of careers parallels the prestige of hospital categories, we ought not to define the prestige of a physician's career by the lesser prestige of the hospital to which he is affiliated if he also has affiliation to a higher prestige hospital.

We see that the question of staff duplication concerns different hospital categories rather than different hospitals;¹ and that, in defining careers, multiple affiliation is mainly a problem with those physicians who combine affiliation at a lower prestige hospital category with affiliation at one of higher prestige.

A physician who has affiliation at both a major teaching and a non-teaching hospital, for example, has not followed a career sequence leading into a practice setting of lesser prestige, since he does have the formal opportunity to practice and take part in the medical affairs of an elite hospital. He should not be included in a category labelled "non-teaching hospital physicians" since his presence in the category would destroy the validity of our statistical description of typical career sequences.

We feel, therefore, that staff duplication ought to be controlled for and not simply ignored, in order to make meaningful the statistics produced and analysed in the next chapter.

There appear to be three ways in which staff duplication could be controlled. First and ideally we could examine each

¹In Tables C:2 and C:3 the difference between attending positions and attending physicians is the number of duplicate positions within the category.

physician's career individually, ascertain which hospital category is the major one in his practice, and then include him in that category and exclude him from all other categories. The collection of such detailed data, however, would have been prohibitively time consuming.

Secondly we could treat physicians with multiple-category affiliation separately. However, there are so many actual combinations of categories among these physicians that the task of arranging them in meaningful physician/hospital categories would have left an excessively large number for analysis in the following chapter. And, indeed, we would still be ignorant of the relative importance of multiple category affiliations in the careers of individual physicians.

The third option seemed more sensible though not ideal: to make certain assumptions concerning medical practice and medical careers on the basis of which we could rule that a physician with a given combination of multiple-category affiliations would be considered affiliated with one of the categories and not affiliated with the other (or others).

We produce by these rules a set of physician/hospital categories (Table C:8) in which not all the English-Montreal attending physicians affiliated with the hospitals of a given category--as shown in Tables C:2 and C:3--are coded in that hospital category for the purposes of career-sequence analysis. Table C:8 thus also gives the number of attending physicians (included in C:2 and C:3 and used in Chapter III) who are

excluded from the categories in Table C:8.¹

In the remainder of this chapter, therefore, and in the next, when we speak of "hospital" categories we really mean "physician/hospital" categories, since each category includes only certain of the physicians affiliated with its hospital(s).

Rules for Controlling Staff Duplication

We will present each rule and then a justification for it.

Rule 1: Public Hospital Physicians

All public hospital (G7 and S6) attending physicians are coded G7/S6 and are excluded from all the categories below.

These hospitals are considered together because of their common characteristics--a marginal position in the status system of English-Montreal hospitals; a restricted population made up largely of older men; institutional practice involving assignment of patients and salaried service; and federal government ownership. Their physicians are "full-time medical staff" with presumably little practice outside of these hospitals.²

Rule 2: General and Special Hospital Physicians

All physicians who have both general hospital (G1 to G6) and special hospital (S1 to S5) attending affiliation are

¹Tables C:6 and C:7 show the distribution by category of hospital affiliation of all attending physicians.

²See Appendix G Tables G:1 to G:8 for this and other distinctive social characteristics of these physicians.

coded in the general-hospital and excluded from the special-hospital categories.¹ The one exception to this rule is proprietary hospital physicians. If they have attending affiliation at a voluntary special hospital, they are coded as special-hospital physicians.

It seems more important for a special-hospital physician to be affiliated with a general hospital than vice versa--66% of special-hospital physicians are in the former situation, and 18% to 25% of general-hospital physicians in the latter (C:6 and C:7).² We observe that 20% of special-hospital and 15% of general-hospital attending physicians have partial affiliation at another hospital (C:2 and C:3); and it appears that, for the special-hospital physicians, this is usually at a general hospital while for the general-hospital physicians it is also usually at a general hospital.³ From this we would conclude that a special-hospital physician who is affiliated with a general hospital most probably has a practice that is divided between the special and the general hospital, and that his general-hospital affiliation is a sufficient indicator of the prestige of his career orbit. While

¹The Neuro (S1) physicians also affiliated with the Royal Victoria, but not affiliated with another voluntary general-hospital, were included in both physician/hospital categories S1 and G1. This is because the Neuro functions as a department of the Royal Victoria and thereby most of its physicians (15 of 19) are attending staff at the latter hospital.

²The figures are 63.95% for acute-special and 78.26% for chronic hospital physicians (C:7).

³Because of the few (72) partial-affiliation positions at special hospitals compared to the general (294).

at least equally intensive treatment is provided in the acute-special hospitals as in the general, it is true that the former are limited to a narrower range of disease (or population), and we would assume that those physicians, who are affiliated with both an acute-special and a general hospital, are relatively less involved in the special hospital's affairs compared to special-hospital-only physicians, and thus their general-hospital affiliation may be taken as the indicator of their status within the system of medical practice.

Certainly for physicians affiliated with both a chronic and a general hospital¹ the above seems a valid assumption since a smaller amount and less intensive medical care is provided at the former,² and thus activity within the chronic hospital is presumably a much less important part of the physician's medical practice.

Proprietary hospital physicians with affiliation at a voluntary special-hospital are coded in the latter categories because of the relatively higher prestige of voluntary hospitals.

¹And with both an acute-special and a chronic hospital as discussed below.

²As discussed in Appendix A, Hospitals section.

Rule 3: "Protestant"¹ General-Hospital Physicians

All physicians² with attending affiliation at both a higher and a lower prestige hospital are coded in the former and excluded from the latter category. This applies to categories G1, G4 and G5. All G1 physicians are coded in that category. All G4 physicians--except those also on staff at G1--are coded in category G4, and so on.

We assume that a physician who has affiliation at a higher and a lower prestige hospital, should be included in the former category, since, while he may in fact practice more in the latter, he has been accorded full membership among the hospital staff of a higher prestige institution and his status is thus relatively greater than his fellow physicians at the lower prestige hospital who do not have this career asset.³

¹"Protestant" in the sense that majority ownership and medical staff control are in the hands of individuals of British Isles ethnic origin traditionally associated with the Protestant churches of Montreal. Except for the Catherine Booth there is no church control of these hospitals. None limit patient service to members of the Protestant community.

²Excluding physicians with attending affiliation at a minority-group hospital, who are treated separately.

³Perhaps these mixed-prestige duplicates are the higher office holders at the lower-prestige hospitals. Thus during 1967 at least two middle-ranking physicians from the Montreal General and Royal Victoria became heads of departments (of anesthesia and psychiatry), one at the Queen Elizabeth and the other at the Reddy Memorial. Quite possibly they would keep their attending staff affiliation at the former hospitals. These cases do suggest that movement from a higher to a lower ranking voluntary hospital may speed up the career advancement process for younger physicians. See the Montreal Star, December 5, 1967 (second date not available).

Rule 4: Jewish and Catholic Hospital Physicians

All physicians with attending staff membership only at a minority group hospital--Jewish or Catholic¹--are coded in two separate categories, one Jewish (G2A) and one Catholic (G3A). All physicians with attending affiliation at a minority-group and a "Protestant" voluntary hospital² are coded in two other separate categories, one Jewish (G2B) and one Catholic (G3B). Jewish General and St. Mary's physicians with duplicate affiliation are treated differently from physicians affiliated with the Protestant hospital category (G4) more-or-less equal in class--the hospitals of all three categories are associated with McGill for graduate teaching. The reasons for this are twofold. First, it has been suggested³ that minority-group physicians who have affiliation at their own group's hospital, but for some reason have limited access to beds or other facilities in that institution, will seek affiliation at a British Protestant hospital in order to increase their standing among their own ethnic community and thus achieve better treatment at their own ethnic hospital. Thus the practice orientation of these physicians remains towards the ethnic hospital.

¹G2, G3, S5 and the Catholic hospital in S4.

²G1, G4, G5, S1, S2, S3 and the 4 Protestant hospitals of S4.

³By Professor Solomon, specifically in connection with Jewish General physicians. However, a similar though less pressing situation presumably maintains for certain Catholic-hospital physicians. Less pressing because there are more beds per attending physician at St. Mary's (4.3) than at the Jewish General (2.1).

Another reason for considering separately the Jewish and Catholic physicians with duplication outside the minority situation, is the historical reticence within the charter community to provide staff membership to minority-group physicians.¹ It could be instructive to examine whether there are differing career sequences between minority-group physicians who have formal acceptance by charter-group hospitals and those who have affiliation only with one of their own hospitals.

Rule 5: Proprietary-Hospital Physicians

All proprietary-hospital physicians are coded in category G6 except those with attending affiliation at a voluntary hospital (general or special).

The voluntary hospitals were found to be of higher prestige than the proprietary in Chapter III, and thus proprietary hospital physicians with a higher prestige affiliation are coded with the latter category.

¹Most people would probably agree that the situation has altered today. However, it is not known to what extent the attitudes encountered by Dr. Goldbloom in the 20's in Montreal are still prevalent. "The interviews were all polite, correct and noncommittal except for one with a member [of the hospital medical staff] who said that the others felt but did not say. . . . He was a professor of medicine and in a position of power. He told me very simply that in a Protestant hospital he would not be disposed to give any major appointment to anyone who was not a Protestant, except under most unusual circumstances. . . . Then it came, 'You must remember Goldbloom, that you are a Jew, and while it makes no difference to me, there are some on the faculty to whom it does. I will undertake to train you, but don't ask for or expect an appointment.'" Alton Goldbloom, Small Patients: The Autobiography of a Children's Doctor (Toronto: Longmans, Green and Company, 1959), p. 189 and p. 129. Certainly the two minority-group hospitals were founded to provide beds for minority physicians who could not get them elsewhere. See, for example, M. B. Etziony, History of the Montreal Clinical Society (Montreal, 1963).

Rule 6: Acute-special Hospital Physicians

All physicians with attending affiliation at S1 are coded in that category, except, as noted earlier, those S1 physicians who are also affiliated with a voluntary general hospital.¹ Physicians with attending affiliation at S2 and S3 but not at S1 are coded in category S2/S3, except those physicians who are also affiliated with a voluntary general hospital.

The assumptions followed in the ranking of S1 and S2/S3 are the same as for the Protestant general hospitals. Because, as we saw in the last chapter, there is no clear prestige differential between the partial-teaching (S2) and non-teaching (S3) acute-special hospitals, we combine these two categories.

Rule 7: Chronic/convalescent Hospital Physicians

We code as S4/S5 those chronic hospital attending physicians who have no affiliation at one of the general or acute-special hospitals.

Chronic hospitals are a relatively limited arena of medical practice and appear to be subsidiary to the general and acute-special hospital affiliations of chronic-hospital physicians.² The distinctive career in this setting, therefore,

¹As also noted earlier, physicians at both the Neuro and the Royal Victoria, but not at another voluntary general hospital, are coded in S1.

²Who hold the greatest number of positions per 100 physicians (226) and have the fewest number of one-position physicians (17.4%) (Table C:1).

appears to be the physician with affiliation only at a chronic hospital, whether Jewish or Christian.

Discussion and Conclusion

Controlling for staff duplication as we have done yields five physician/hospital categories with less than 45 physicians in each. Thus the percentage differences we consider in the next chapter may not always be statistically significant. However, if we have managed to set up career-meaningful physician/hospital categories, differences in the composition of hospital staffs may be interesting and instructive even though not statistically significant.¹ This reservation applies especially to the 13 physicians only at a chronic hospital (S4/S5) and to the 30 public-hospital physicians (G7/S6).

In the next chapter we will examine the associations among birthplace, medical school and type of hospital affiliation for physicians in the categories we have developed in this chapter.

¹The reader with a special interest in details of the medical profession in Montreal is referred to Appendix G where social characteristics of English-Montreal physicians are displayed.

CHAPTER V

BIRTHPLACE AND MEDICAL SCHOOL: ELEMENTS OF THE SORTING PROCESS

In Chapter III we examined whether there is an ethnic/religious and class system among the hospitals of English Montreal. We presented data that showed such a system to exist. The parts of the system exhibit important differences in prestige. In this chapter we want to examine certain attributes of the careers of physicians--birthplace, medical school and hospital affiliation--in order to test the hypothesis that physicians are not randomly distributed among the hospital categories,¹ but rather that the different categories depend upon physicians with particular career-sequence backgrounds. If our hypothesis tests out we will have shown that birthplace, medical school and hospital affiliation are indeed "contingencies" in physicians' careers"which are decisive for the success of the practitioners."²

¹"Hospital categories" are really physician/hospital categories since staff duplication is controlled for as described in Chapter IV. They may also be considered as partial "practice settings."

²Solomon, "Ethnic and Class Differences among Hospitals . . .," p. 463. See Chapter I for a fuller definition of contingencies.

Purpose

An occupational role has among its various aspects, the institutional structure wherein the role is played out, and the careers of members of the occupation. We have already examined an important element of the institutional structure surrounding the physician role--the hospital. In this chapter we want to describe the different career sequences and life chances of physicians in different parts of the hospital system. We seek to learn whether, in this large urban community, there is a pattern of sorting of physicians--in terms of birthplace and medical school--that is associated with the differential prestige of hospital categories as established in Chapter III.

This inquiry aims to set out patterns of association between hospital affiliation, birthplace and medical school as they may be described statistically. It would require further and more qualitative research to learn the full meaning of the statistical associations we expect to find. Some of this research will be suggested in the following chapter.

In the first part of the data analysis we will examine characteristic career sequences of birthplace and medical school in hospital affiliation categories. In the second part we will examine the "life chances"¹ physicians with particular

¹Our use of the term "life chances" seems to be inexact, since life chances can only be calculated for all potential Montreal physicians, including those who have left as well as those who have stayed. We retain the term for want of a more exact one. It relates to those physicians who are found within English Montreal at a given point of time.

social backgrounds have of gaining access to different hospital-affiliation categories.

Hypothesis

In order to guide our collection and examination of data we postulated the hypothesis that the hospital-affiliation categories depend differently upon physicians with particular social backgrounds. In considering characteristic careers in hospital-affiliation categories, we hypothesized that the higher-prestige categories would have relatively higher representation of physicians with background characteristics readily assimilable¹ to those of the British Protestant charter² community of English Montreal; and conversely that the lower-prestige categories would have a relatively high representation of physicians with characteristics less readily assimilable to those of the charter community.³ We hypothesized that

¹This seems to be one meaning of the term social homogeneity. See John Porter, op. cit., p. 447. By ready assimilability we do not necessarily mean locally born and trained.

²This concept is important in John Porter's study of social class and power in Canada: "In any society which has to seek members from outside there will be varying judgments about the extensive reservoirs of recruits that exist in the world. In this process of evaluation the first ethnic group to come into previously unpopulated territory, as the effective possessor, has the most say. This group becomes the charter group of the society, and among the many privileges and prerogatives which it retains are decisions about what other groups are to be let in and what they will be permitted to do." The Vertical Mosaic, p. 60. The two charter groups in Canada, Porter points out, are the French and the British. In English Montreal the population of British Isles origin equals that of all other non-French origins. See Appendix E Table E:2.

³For reasons discussed in Appendix D we assume that non-English physicians who were trained in Eastern Europe are less easily assimilable than those trained in Western Europe.

categories of middle prestige would rank between these two extremes.

In considering the life chances of physicians, we hypothesized that physicians with readily assimilable social backgrounds would have high chances of being affiliated with the high-prestige categories, while physicians with backgrounds presumably less readily assimilable would have progressively higher chances of being affiliated with the lesser-prestige hospital-affiliation categories.

These hypotheses are based upon the findings of Professor Solomon's study of Chicago physicians and hospitals.¹ In terms of the three variables examined--medical school, location of internship/residency and hospital affiliation--he found that the elite Protestant hospitals, compared to the mixed category of lesser-prestige hospitals, showed significantly more social homogeneity in the characteristics of their physicians, while the voluntary Jewish and Catholic hospitals ranked between the two. We hypothesize that a similar social selection of physicians will be evident in the English-Montreal hospital system.

We might note that, in replicating Solomon's study it would have been preferable to employ the same variables. However, data on location of internship/residency were not available in any collected form. To gather them seemed beyond the

¹"Career Contingencies of Chicago Physicians," and "Ethnic and Class Differences among Hospitals as Contingencies in Medical Careers." I am greatly indebted to Professor Solomon's Chapter IV in the first work cited for the methodology of this chapter.

scope of this study.¹

The variable we substituted--birthplace--was selected for the availability of data as well as for its sociological significance.²

Variables

A few points may be made about two of the variables we will examine; the third is hospital affiliation.

Birthplace

Being born in a given country or region implies something about a person's early socialization, about the social characteristics he inherited through birth into a national, linguistic or regional community. If the person also completed his professional education within the same general area, this signifies his exposure for an important period to

¹We might note also that it would be very difficult to categorize the internships/residencies of English-Montreal physicians compared to those of Chicago physicians, since 39.7% of the former went to medical schools outside of Quebec, while something less than 21.9% of the latter went to medical schools outside of Illinois. Presumably the range of hospitals where English-Montreal physicians did their internship/residency would be greater than for Chicago physicians. See Solomon, "Career Contingencies . . .," p. 50.

²The attributes Professor Solomon studied were more ideally matched since they form a natural chain of institutions: "The graduates of the various medical schools are by no means distributed randomly through the different types of hospitals; rather, each type appears to have, to some degree, its own peculiar preferences for graduates of particular schools. . . . Similarly, each type of hospital has a marked preference for doctors who have trained as interns or residents in the same type. There are thus 'typical chains in which each institution aids the newcomer along to the next level' and which function as devices which sort or allocate incumbents to various sectors of the system." Solomon, "Ethnic and Class Differences among Hospitals . . .," pp. 469-70.

a particular set of socialization forces.¹ If he came to this country prior to his medical training, this indicates that he has first-generation immigrant standing in Canada.²

Birthplace, thus, reflects upon the pre-professional socialization stage of a prospective physician's career.

Medical School

Attendance at a given medical school is obviously highly important in a physician's career. Solomon has shown the link between attendance at prestigious medical schools and obtaining equally desirable internships/residencies. He has also shown the further linkage between prestigious internships/residencies and obtaining affiliation at a prestigious hospital. The converse of these findings was also established.³

Another important connection is that between medical school and specialization. Stanley Lieberman found that having specialty qualification was associated with graduation

¹"Homogeneity results from common socialization processes and from common interaction." John Porter, op. cit., p. 447.

²Foreign birthplace is important in Canada because of our heavy reliance upon physicians who were born abroad. Thus, in 1961, 25.3% of Canadian physicians were foreign born. See 1961 Census of Canada, Occupations by Sex, Showing Birthplace etc., Bulletin 3.1--15 (Ottawa: Queen's Printer, 1964). In our study 26.7% of physicians are foreign born. See Appendix D Table D:7.

³"These early 'choices' of medical school and internship are probably the most important of the career, since to a large extent they determine the individual's later position in the social structure of medicine." Solomon, "Career Contingencies of Chicago Physicians," p. 151; see also pp. 93-115.

from particular medical schools, even controlling for the different ethnic-origin mixes of medical school graduates.¹

Medical school is the first major professional socialization of a prospective physician. Here he acquires the formal and informal skills, the attitudes and values that go to make up the physician role. Here he usually makes the first close contacts with senior physicians who will play a role in the sponsoring process, so important to success as the physician moves along the chain of professional roles.² Being exposed to the same or similar educational processes helps to produce a homogeneity of social type.³

Medical school⁴ thus has an important bearing upon the

¹Stanley Lieberman, "Ethnic Groups and the Practice of Medicine," ASR, XXIII (October, 1958), 542-49.

²The interview data collected by Oswald Hall and David N. Solomon, emphasize this sponsoring process. Hall, "The Informal Organization of Medical Practice in an American City," pp. 101-254; Solomon, op. cit., pp. 71-154.

³"This common educational background can make for homogeneity of social type." Porter, op. cit., p. 277.

⁴John Porter has emphasized the importance of variables such as birthplace and medical school in the selection of persons into the economic, bureaucratic, labor, political, and ideological elites: "In every society there are established mechanisms by which members are sorted out and assigned to particular social tasks. . . . In addition to these very obvious biological differences [sex and color] social characteristics have also been used in this assignment of people to social tasks. Religion, ethnic affiliation, educational experience, social class, and other such characteristics are often treated as biological attributes even though they are socially rather than genetically acquired. . . .

. . . . Values and beliefs are as important as technical competence and they are acquired through socializing agencies such as families, schools and clubs. Some of these agencies become the preferred sources of recruits to elite roles." Ibid., pp. 264 and 265.

development of a physician's career and may be expected to play a role in sorting physicians into different hospital categories.¹

General-Hospital Physicians: Characteristic Careers in Hospital Categories

Methodology

The data we analyse in this section are presented in Appendix D Table D:1.² Like Table D:2, this table shows, in each hospital category, the proportion of all its physicians who have both a particular birthplace and a particular medical school background. Thus each cell represents a career sequence. We will examine each hospital category, reporting on which career sequences are relatively common and which are relatively few. We report as common, those career sequences in which the category has the highest or second highest proportion compared to the other general-hospital categories. We report as rare those career sequences in which the category has the lowest or second lowest proportion. For purposes of comparison we show the proportions in the two categories that occur at the other end of the frequency scale. Thus if the major-teaching hospitals score high on the proportion of

¹Hospital categories are sometimes referred to by short-hand descriptions--"partial teaching" for example--that do not adequately differentiate among them. They are used for simplicity. The included hospitals are shown in Appendix B Tables B:2 and B:11. The categories are sometimes numbered--G1, G2, etc. The included hospitals are shown in Appendix C Tables C:4 and C:5.

²Tables D:7 to D:12 present data additional to the analysis of this chapter on birthplace and medical school and on length of time in Canada.

physicians Canadian born and trained at McGill and Toronto, we compare this to the two categories where this sequence is most rare, the proprietary and non-teaching.

We will examine the categories in this order, G1, G4, G5, G6, then the G2 and G3 categories. Thus, we look at the non minority-group hospitals in order of prestige ranking: the major teaching, then the "other" partial teaching, the non-teaching and the proprietary. Then we examine the Jewish and Catholic hospitals.

In order to make the main pattern apparent, in each column of Table D:1 figures in cells (other than total cells) containing 10% or more of the cases have been underlined and in Table 1¹ below the data are shown in summary form. We note that only two categories, the less prestigious, depend on French Canadian² physicians. While every category but one depends upon Quebec born and McGill trained physicians, there is considerable variation among categories. Only half the categories depend upon physicians born and educated outside Quebec. No category draws very much upon physicians trained in English countries. The major-teaching hospitals do not depend upon physicians born and educated in non-English countries, while all but one of the other categories do. We analyse below the additional differences observable in Table D:1.

¹In summary Tables 1 and 2 we do not show any of the total or subtotal cells of the corresponding tables in Appendix D.

²It would seem that the graduates of French Canadian universities are French Canadians. In this study 144 physicians have French preferred language, 143 have French ethnic origin, and 138 are graduates of French Canadian universities.

TABLE 1.--Summary table showing the more common career sequences (in percentages) in each hospital category: general-hospital physicians

Birthplace	Medical School					Total Per Cent (N = 100%)
	French Canada	McGill	Other Canada	English Countries	Non-English Countries	
	%	%	%	%	%	
Major Teaching: G1						
Quebec	..	37	} 69 (342)
Other Canada	..	16	16	..	..
English ^a	
Non-English	
Partial Teaching: Jewish G2A						
Quebec	..	52	} 62 (125)
Other Canada	
English	
Non-English	10	
Partial Teaching: Jewish G2B						
Quebec	..	54	} 64 (69)
Other Canada	10	..	..
English	
Non-English	
Partial Teaching: Catholic: G3A						
Quebec	..	32	} 55 (44)
Other Canada	
English	
Non-English	23	
Partial Teaching: Catholic: G3B						
Quebec	..	42	} 84 (38)
Other Canada	..	13	13	..	..
English	
Non-English	16	
Other Partial Teaching: G4						
Quebec	..	42	} 75 (91)
Other Canada	..	11	..	..	..
English	
Non-English	22	
Non-Teaching: G5						
Quebec	10	26	} 68 (84)
Other Canada	10	..	..
English	
Non-English	23	
Proprietary: G6						
Quebec	54	} 76 (83)
Other Canada	
English	
Non-English	22	

For hospitals included in these categories see Appendix C Table C:4.

^aEnglish foreign countries.

(..) = less than 10 per cent.

Major Teaching Hospitals: G1

Common (career sequences): Born in Canada outside Quebec, educated at McGill, 16%; compared to the proprietary hospitals, nil, and the Jewish-plus,¹ 3%. Born and educated in Canada outside Quebec, 16%; compared to proprietary, nil, and Jewish-only, 6%. Born abroad and educated in English countries, 8%; compared to proprietary, nil, and Jewish-only, 2%. Born and educated in Canada, 76%; compared to Catholic-only, 57%, and non-teaching, 62%.

Rare (career sequences): Born and educated in Quebec, 40%; compared to proprietary, 60%, and Jewish-plus, 62%. Born in Quebec and educated at French Canadian medical schools, 3%; compared to proprietary, 54% and non-teaching, 10%. Born and educated in non-English countries, 6%; compared to Catholic-only, 23%, and non-teaching, 23%. Born and educated in non-English countries other than Western Europe, 2%; compared to proprietary, 16%, and non-teaching, 12%.

This high-prestige category contrasts with the lower-prestige non-teaching and proprietary, and with the minority-group hospitals. The contrast with the former categories is associated with the considerable difference in prestige. The contrast with the minority-group hospitals is associated more with the structure of the minority communities as we shall

¹We use the terms "Jewish-only" and "Catholic-only" to indicate the physicians of categories G2A and G3A. We use the "Jewish-plus" and "Catholic-plus" to indicate physicians of G2B and G3B. The "plus" refers to affiliation with a voluntary Protestant hospital as well as a minority-group hospital. The "only" refers to physicians with affiliation only at a minority-group hospital. This was explained more fully in Chapter IV.

see below. The major-teaching depend heavily on physicians born and trained in Canada. Where they draw upon foreign-trained physicians, they select those educated in English rather than non-English countries. The category depends upon physicians who are geographically mobile across Canada--16% born outside Quebec, educated at McGill,¹ 16% born and educated in Canada outside Quebec. Presumably the latter move to Quebec, among other reasons, because of the opportunity of being affiliated with a high-prestige hospital. Presumably, also, the hospital selects these physicians because they have excelled in their education or practice. We shall notice again this association between mobility within Canada and the relatively high prestige of the practice setting. We should note that selecting readily-assimilable physicians does not mean selecting the locally born and trained, since this category has fewer Quebec born and McGill trained than four other general-hospital categories.

¹We might ask whether the physicians born in Canada outside Quebec and educated at McGill came to the province especially for their medical education. We do not know. However, we note in Table D:1 an association between the proportion of such physicians and the prestige of the hospital category. Perhaps outstanding medical students from Canada outside Quebec are offered opportunities within the higher-prestige hospitals and therefore decide to remain in Montreal. The others return home and thus are not found in as great numbers in the other hospitals. See Tables 3 and D:3. Perhaps, of course, these persons moved to Montreal prior to their medical education. The Census shows that only 22% of Montreal residents born in Canada outside Quebec are under 20 years of age, compared to 44% of Montreal residents born within Quebec. This seems to argue that Canadians who migrate to Montreal do so at an age equal to or older than the age of entry to medical school. See 1961 Census of Canada, Birthplace and Citizenship by Age Groups, Bulletin 1.3--4 (Ottawa: Queen's Printer, 1963), pp. 92-4.

Other Partial Teaching: G4

Common: Born and educated in non-English countries, 22%; compared to Jewish-plus, 4%, and major teaching, 6%.

Compared to the major-teaching, this category has fewer Canadian born and trained physicians (67% to 76%). It has slightly fewer McGill and Toronto graduates (57% to 59%); fewer physicians born and educated in Canada outside Quebec (6% to 16%). It has more physicians born and educated in non-English countries (22% to 6%). There is less similarity between these physicians' backgrounds and the charter community of English Montreal, than at the major-teaching. We might note that there are somewhat more physicians born in Quebec and educated at McGill.

Non-Teaching: G5

Common: Born in Quebec, educated at French Canadian universities, 10%; compared to Catholic-plus, nil, and major-teaching, 3%. Born and educated in foreign English countries, 8%; compared to proprietary, nil, and Jewish-only, 1%. Born in non-English countries, educated in Western Europe, 11%; compared to Jewish-plus, 1%, and major-teaching, 3%. Born and educated in non-English countries, 23%; compared to Jewish-plus, 4%, and major-teaching, 6%.

Rare: Born in Quebec, educated at McGill, 26%; compared to Jewish-only, 52%, and Jewish-plus, 54%. Born in Canada, educated in Canada, 62%; compared to Jewish-plus, 84%, and major-teaching, 76%.

This category shows greater heterogeneity than the previous one. More French Canadians (10% to 4%); fewer McGill

and Toronto graduates (35% to 57%); fewer Canadian born and trained (62% to 67%); more physicians born and educated abroad (31% to 24%).

We might note that there are more physicians born and educated in Canada outside Quebec (9% to 6%) and more born and educated in English countries (8% to 2%). This indicates that something other than social similarity is also at work in the sorting of physicians. Perhaps some physicians who move to Montreal from other parts of Canada do so for reasons other than career-advancement. And, lacking special qualifications, they are more concentrated in the lower-prestige non-teaching hospitals. In any case education in an English country does not automatically lead to a better hospital affiliation. Presumably factors such as qualifications, reputation and sponsorship are also at work here.

Proprietary: G6

Common: Born in Quebec, educated at French Canadian universities, 54% compared to Catholic-plus, nil, and major-teaching, 3%. Born and educated in non-English countries, 22%; compared to Jewish-plus, 4%, and major-teaching, 6%. Born abroad and educated in Eastern Europe, 14%; compared to 2% at the major teaching, Jewish-only and Jewish-plus categories.

Rare: Born in Quebec, educated at McGill, 6%; compared to the two Jewish categories both over 50%. Born in Canada outside Quebec, educated at McGill, nil; compared to major-teaching, 16%, and Catholic-plus, 13%. Born and educated

in Canada outside Quebec, nil; compared to major-teaching, 16%, and Catholic-plus, 13%. Born and educated in English foreign countries, nil; compared to Catholic-plus, 8%, and Catholic-only, 7%.

Compared to the previous category and indeed to all general-hospital categories, these physicians are the least similar to those of the charter community of English Montreal. Relative to the previous category, more are French Canadians (54% to 10%); fewer are McGill and Toronto trained (6% to 35%); fewer are born and educated in English countries (nil to 8%). While about the same proportion were born and educated in non-English countries (22% to 23%), more were born in non-English countries and educated in non-English countries other than Western Europe (16% to 12%--derived from inspection). The hospitals of lowest prestige, thus, are staffed mostly by French Canadians. Indeed 76% of physicians are either French Canadians or non-English foreigners. There must be historical reasons for the English-Montreal proprietary hospitals being so heavily staffed by French Canadians. But this is one measure of the social distance between these physicians and the most prestigious and presumably influential physicians at the major-teaching hospitals.

Jewish General: G2A and G2B

We will examine the data separately, but will comment on both the Jewish categories together (and later both the Catholic categories) since they relate to the same hospital.

Jewish-only: G2A, Common: Born in Quebec, educated at McGill, 52%; compared to proprietary, 6%, and non-teaching, 26%. Born in Quebec, educated abroad, 6%; compared to Catholic-plus, nil.

Jewish only: Rare: Born and educated in Canada outside Quebec, 6%; compared to major teaching, 16%, and Catholic-plus, 13%. Born and educated abroad, 12%; compared to the non-teaching, 31%, and the Catholic-only, 30%.

Jewish-plus: G2B, Common: Quebec born, educated at McGill, 54%; compared to the proprietary, 6%, and non-teaching, 26%. Born and educated in Canada, 84%; compared to the Catholic-only, 57%, and the non-teaching, 62%.

Jewish-plus: Rare: Born and educated in non-English countries, 4%; compared to the non-teaching, 23%, and the Catholic-only, 23%. Born and educated abroad, 9%; compared to the non-teaching, 31%, and Catholic-only, 30%.

On common and rare career sequences this hospital is contrasted with each of the other general-hospital categories, suggesting that career sequences are not as closely linked with prestige as at other categories. While this hospital ranks below the major-teaching in prestige, it ranks above the latter in the homogeneity of its physicians in terms of birthplace and medical school. However, we know from Chapter III that these are mostly Jewish physicians.¹ They are therefore ethnically dissimilar to the charter community of

¹See Appendix B Table B:7, and Appendix A, Physicians section where the number of Jewish physicians is also discussed.

English Montreal, even though they might have the "right" birthplace and medical school. We note that they have the highest proportions of McGill and Toronto graduates, 62% and 61% respectively. The most important social characteristic of these physicians, then, seems to be their Jewish-community identification. There are some interesting characteristics about these two categories. First, they are highly local operations. We see this from the proportions of Quebec born and McGill trained, 52% and 54%; of Quebec born and Quebec trained (58% and 62%--compared to 40% at the major-teaching); and the relatively few physicians born and educated abroad (12% and 9%). On the other hand there are somewhat higher proportions of physicians born in Quebec and educated elsewhere, and of physicians born in Canada and educated abroad. This may relate to the large number of Jewish physicians per Jewish population,¹ as well as to some difficulty in getting into the local medical school.

Second, although the Jewish community contains many immigrants,² the Jewish hospital contains relatively few immigrant physicians. Perhaps because of the large number of physicians produced by the native Jewish community, there is a need for the immigrant physicians to seek beds elsewhere,

¹In Montreal, 1964, there were 3.00 Jewish physicians per 1000 Jewish population, 1.93 British Isles physicians per 1000 British Isles population, and 1.67 French physicians per 1000 French population. For Jewish and British Isles physicians in private practice the numbers were 2.20 and 1.31. See Guy Demers, op. cit., p. 65.

²See Chapter III page 26 where this is discussed.

and this is why they are so much involved in the proprietary hospitals.¹ It is interesting that the Jewish-plus category--those who have formal affiliation with a British Protestant hospital--exhibits more social homogeneity than the Jewish-only. We will notice the same phenomena at the Catholic hospital.

St. Mary's: G3A and G3B

Catholic-only: G3A: Common: Born in non-English countries, educated in Western Europe, 16%; compared to Jewish-plus, 1%, and major-teaching, 3%. Born and educated abroad, 30%; compared to Jewish-plus, 9%, and Jewish only, 12%.

Catholic-only: Rare: Born and educated in Canada, 57%; compared to Jewish-plus, 84%, and major teaching, 76%.

Catholic-plus: G3B: Common: Born in Canada outside Quebec, educated at McGill, 13%; compared to proprietary, nil, and Jewish-plus, 3%. Born and educated in Canada outside Quebec, 13%; compared to proprietary, nil, and Jewish-only, 6%.

Catholic-plus: Rare: Born in Canada and educated abroad, nil; compared to Jewish only, 7%, and proprietary, 6%.

Like the Jewish we find this category contrasted with each of the other general-hospital categories on common and rare career sequences, suggesting here also that this hospital's prestige is not the main factor associated with careers.

The important features about these career sequences are the relatively few Canadian born and trained at the

¹See Appendix B Table B:7.

Catholic-only and the high proportion of physicians born and educated abroad. We found in Chapter III that this hospital ranked somewhat below the Jewish General in prestige according to hospital characteristics, although it ranked somewhat above it on certain physician characteristics. It is quite unlike the Jewish General, however, in the characteristic careers of its physicians, although it is quite like the "other" partial teaching with which it is more or less ranked in prestige. It is much less of a local operation than the Jewish General. This may be related to a greater number of immigrants who are considered members of the English-Catholic¹ community. There are, however, many immigrants among the Jewish community also. Possibly the differences between the two hospitals relate more to the availability of beds to physicians of the two minority communities. We note that the Catholic-plus are more homogeneous than the Catholic-only, another indication that a physician's position within the system of medical practice is contingent in part on his social background.

Summary

We have observed in this section that there are considerable differences in career sequences of physicians at different hospitals. Considering the non minority-group hospitals, we found that as we move down the prestige ladder of categories from the major-teaching, to the partial teaching,

¹As we saw in Chapter III page 27, of the estimated 262,000 English Catholics, 135,332, 51.5%, are of non British Isles origin. Perhaps 60% of these were born outside Canada.

the non-teaching (voluntary-hospital categories), and the proprietary, we notice increasing heterogeneity among physicians, an increasing importance of social backgrounds less readily assimilable to those of members of the British Protestant charter community of English Montreal.

In considering the two minority-group hospitals we note that the social characteristics of their physicians are not associated with the relative prestige of the hospitals as much as with the structure of the minority-group community. For these physicians, then, we find that the most important aspect of their social background seems to be their identification with a minority-group community within English Montreal. This relates to our finding in Chapter III that the most important prestige characteristic of these hospitals is their formal identification with a minority-group.

Finally, the greatest contrast in relative homogeneity of physicians is between the major-teaching and the Jewish General on the one hand, and all other hospital categories on the other.

All Physicians: Characteristics Careers in Hospital-Affiliation Categories

Methodology

The data we analyse in this section are presented in Appendix D Table D:2.¹ In examining these data we follow virtually the same system as for general-hospital physicians, presenting common and rare career sequences. We will examine

¹The data on all general hospital are included there for purposes of comparison.

the three special-hospital and the public-hospital categories together comparing them to each other. Although not a homogeneous set, they are alike in that each has a special medical function. We include both public hospitals together for reasons mentioned in Chapter IV. We first look at the three special-hospital and the public-hospital categories comparing them to each other and to the general hospitals. Then we will examine the main categories of hospital affiliation.

In order to make the main pattern apparent, in each column of Table D:2 figures in cells (other than total cells) containing 10% or more of the cases have been underlined, and in Table 2 below the data are shown in summary form.¹

We note first of all that French Canadian physicians are well represented in each of the special and public-hospital categories. They were only heavily represented in the less-prestigious general-hospital categories we saw. On the other hand Quebec born and McGill trained physicians are relatively under-represented in these categories, indicating their greater heterogeneity compared to most general-hospital categories. We note in Tables 1 and 2 that the major-teaching special hospitals have most cells each containing 10% or more of the cases, while the other acute-special hospital have the highest proportion of physicians born and educated in non-English countries. The "right" social background does not seem as important, therefore, in the acute-special hospital categories.

¹The data on all general hospitals are included for purposes of comparison.

TABLE 2.--Summary table showing the more common career sequences (in percentage) in each hospital-affiliation category: all physicians

Birthplace	Medical School					Total Per Cent (N=100%)
	French Canada	McGill	Other Canada	English Countries	Non-English Countries	
	%	%	%	%	%	
General Hospitals: G1 to G6						
Quebec	10	37	} 79 (872)
Other Canada	..	10	10	..	..
English ^a	
Non-English	12	
Special Hospitals: Major Teaching: S1						
Quebec	15	21	} 83 (71)
Other Canada	..	10	14	..	..
English	11	..	
Non-English	11	
Special Hospitals: Other Acute: S2 & S3						
Quebec	12	15	} 64 (33)
Other Canada	
English	
Non-English	36	
Special Hospitals: Chronic: S4 & S5						
Quebec	23	31	} 69 (13)
Other Canada	..	15	..	..	..
English	
Non-English	
Public Hospitals: G7 & S6						
Quebec	23	23	} 77 (30)
Other Canada	..	10	..	..	..
English	
Non-English	20	
Attending Physicians						
Quebec	11	35	} 79 (1008)
Other Canada	..	10	10	..	..
English	
Non-English	13	
Unaffiliated Physicians						
Quebec	..	29	} 63 (186)
Other Canada	
English	
Non-English	34	
Partial Affiliation Only						
Quebec	..	25	} 61 (67)
Other Canada	10	..	..
English	
Non-English	25	
Consulting Affiliation Only						
Quebec	..	60	} 76 (137)
Other Canada	..	16	..	..	..
English	
Non-English	

For hospitals included in these categories see Appendix C Table C:5.

^aEnglish foreign countries.
(..) = less than 10 per cent.

We analyse below the additional differences observable in Table D:2.

Major Teaching: S1

Common: Born and educated in Canada outside Quebec, 14% (general hospitals:¹ major-teaching, 16%); compared to the public hospitals, 3%, and the proprietary hospitals, nil. Born and educated in English foreign countries, 11% (general hospitals: Catholic-plus and non-teaching, 8%); compared to public hospitals, nil, and proprietary hospitals, nil.

We note interesting features about this category. First of all it ranks above the other-acute special in the homogeneity of its physicians as it ranks above them in prestige as we saw in Chapter III. However, these physicians are much more heterogeneous than those at the major-teaching general--hospitals similar in prestige. There are more French Canadians at the former (15% to 3%); fewer Quebec born and McGill trained (21% to 37%); fewer McGill and Toronto trained (37% to 59%); fewer Canadian born and trained (66% to 76%); more physicians born and educated abroad (24% to 14%); and more born and educated in non-English countries (11% to 6%). This suggests that while there are career differences related to prestige among special hospitals, having the right social background is not as important as at the general hospitals.

¹We show the general hospital category which also ranks high in this career sequence. And we compare the common and rare career sequences to one other of the special or public hospital categories and to one of the general-hospital categories.

Other Acute-Special: S2/S3

Common: Born abroad, educated in Western Europe, 21% (general hospitals: Catholic-only, 16%); compared to major-teaching,¹ 6%, and Jewish-plus, 1%. Born abroad, educated in non-English countries other than Western Europe, 15% (general hospitals: proprietary, 16%); compared to chronic and public hospitals, nil, and major-teaching general hospitals, 2%. Born abroad, educated abroad, 45% (general hospital: non-teaching, 31%); compared to chronic hospitals, 15%, and Jewish-plus 9%.

Rare: Born in Quebec, educated at McGill, 15% (general hospitals: proprietary, 6%); compared to chronic hospitals, 31%, and Jewish-plus, 54%. Born and educated in Canada, 42% (general hospitals: Catholic-only, 57%); compared to chronic hospitals, 77%, and Jewish-plus, 84%.

This would seem to be the most heterogeneous practice setting of all. It is significant that it is an acute-special hospital. At the same time it is a less prestigious and more restricted practice setting. Again, if we compare it to the similar general-hospital categories--the other partial teaching and the non-teaching--we find greater heterogeneity in social background of its physicians, suggesting once again that prestige and background of physicians are not as important in the acute-special hospital setting. It does of course show greater heterogeneity than the more prestigious major-teaching category.

¹"Major-teaching" in this section refers to the major-teaching special hospitals, S1.

Chronic Hospitals: S4/S5

Common: Born in Quebec, educated at French Canadian universities, 23% (general hospitals: proprietary, 54%); compared to other acute-special hospitals, 12%, and Catholic-plus, nil. Born in Canada outside Quebec, educated at McGill, 15% (general hospitals: major teaching, 16%); compared to other acute special, 6%, and proprietary, nil.

Rare: Born and educated abroad, 15% (general hospitals: Jewish-plus, 9%); compared to other acute special, 45%, and non-teaching hospitals, 31%.

This lower prestige and relatively restricted practice setting has a high proportion of French Canadian physicians. We assume that the category would rank below most acute-special hospitals because of the limited quantity of medical care, the lack of medical urgency, and the many charity cases among patients.¹ However, apart from French Canadians, the physicians seem quite readily assimilable to the British Protestant community. The explanation for this may probably be found in Appendix G Table G:1 where we note that this is an older category of physicians (54% aged 55 and over, compared to 20% among all attending physicians). Compared to the other special-hospital categories the differences in proportions resemble those between the consulting-only category (also older physicians) and the attending. Perhaps as a pre-retirement setting attracting older physicians, its prestige and advantage are relatively unimportant in the physicians' practices.

¹Interviews 6 and 13.

Public Hospitals: G7/S6

Common: Born in Quebec, educated at French Canadian universities, 23% (general hospitals: proprietary, 54%); compared to other acute-special, 12%, and Catholic-plus, nil. Born outside Quebec educated at French Canadian universities, 7% (general hospitals: non-teaching, 5%); compared to nil in the other three special-hospital categories, and nil in five general-hospital categories.

Rare: Born and educated in other parts of Canada, 3% (general-hospitals: proprietary, nil); compared to major-teaching special, 14%, and major-teaching general, 16%.

This lower-prestige practice setting has a high concentration of French Canadian physicians, a phenomenon we have observed several times before. It also has a small proportion of physicians born and educated in Canada outside Quebec. Not being an advantageous setting it does not attract physicians from other parts of Canada. It has a proportion of physicians born and trained abroad comparable to several general-hospital categories. However, it has a higher proportion of Eastern European physicians than other categories. Of little importance in private practice and of lower standing in the hospital-class-system, we would expect these characteristics.

Unaffiliated Physicians

Common:¹ Born abroad, educated in non-English countries other than Western Europe, 20%. Born abroad, educated in

¹For this category and the next two data on common and rare career sequences are presented without comparison to unlike categories.

Eastern European countries, 16%. Born and educated abroad, 38%.

Rare: Born and educated in Canada, 53%.

This is presumably the least prestigious of the hospital-affiliation categories since the physicians have no formal affiliation to an English-Montreal hospital.¹ Comparing the unaffiliated to all attending physicians we find fewer McGill and Toronto trained among the unaffiliated (38% to 49%); fewer Canadian born and educated (53% to 71%); more born and educated abroad (38% to 19%); more born in non-English countries and educated in Western Europe (13% to 6%); and more born in non-English countries and educated in non-English countries other than Western Europe (20% to 7%). Apart from the other acute-special hospitals this is, expectedly, the most heterogeneous category of hospital affiliation.²

Partial Affiliation Only

This category does not rank among the two most common or two rarest career sequences in any major cells. However, if we compare it with all attending and with unaffiliated physicians, we note that it ranks between the two in the heterogeneity of its physicians. It is a considerably more advantageous practice setting compared to the unaffiliated not only because the physicians have a formal affiliation to

¹The question whether these physicians are perhaps affiliated with a French-Montreal hospital is examined in Appendix A, Hospitals section. We conclude that the great majority are not.

²Social characteristics of unaffiliated and attending physicians are compared in Appendix G.

a hospital but because this is frequently a prelude to full participation in the attending staff.¹ We might note that, expectedly, there is greater heterogeneity in social background among the partially affiliated than among any category other than the other acute-special.

Consulting-Only

Common: Born in Quebec, educated at McGill, 60% (general hospitals: Jewish-plus, 54%; special hospitals: chronic, 31%). Born and educated in Canada, 88% (general hospitals: Jewish-plus, 84%; special hospitals: chronic: 77%).

Rare: Born and educated abroad, 4% (general hospitals: Jewish-plus, 9%; special hospitals: chronic, 15%).

This is by far the most homogeneous category of physicians. If we consider the consulting-only as a representative sample of the previous generation² of attending physicians, we note that English Montreal medicine has become much more heterogeneous in the social backgrounds of its physicians in all hospital affiliation categories. For whatever reasons of career choice, staff selection and general immigration, English-Montreal medicine has become a much more socially open system.

Summary

We found that, for the acute-special hospitals there is an association between the prestige of the category and the

¹This is discussed in Appendix A, Hospitals section. It is interesting to contrast the social characteristics of the unaffiliated and partially affiliated in Appendix G.

²93% aged 55 and over, 72% 65 and over, compared to attending physicians, 20% and 2%. See Appendix G Table G:1.

relative homogeneity in social background of physicians. The higher-prestige major-teaching hospitals are more homogeneous than the lower-prestige other acute-special hospitals. However, more importantly, we found that, as a category, the acute-special hospitals are more heterogeneous than general hospitals of comparable prestige. For some reason probably connected with the nature of specialty practice, acute-special hospitals are more socially open than comparable general hospitals.

Although the chronic hospitals and practice confined to them is not of high prestige, we found a homogeneity among these physicians relative to other special hospitals. This, we suggest, is due to this practice setting apparently being a pre-retirement activity for physicians. Again we note that where the association between high-prestige and homogeneity of physicians is not maintained there are special characteristics of the hospital category and about practice in the category that produce the unexpected result.

The public hospitals, which we saw in Chapter III are of lower prestige within the English-Montreal hospital system, are among the most heterogeneous in terms of their physicians' backgrounds.

In considering the main categories of hospital-affiliation we found, as expected, that the unaffiliated (apart from the "other" acute-special hospitals) is the most heterogeneous category. We found that the partially affiliated rank next to the unaffiliated. The consulting-only

category serves to suggest to what extent the hospital system of English Montreal has become socially heterogeneous during the past generation. Finally, we have noted an association between the high-prestige of the practice setting and a relatively high proportion of physicians born and trained in Canada outside Quebec. Geographical mobility within the country, thus, appears to be in part a function of relative opportunity, something we would indeed expect.

In examining the general and other hospital and hospital-affiliation categories we have found our hypothesis confirmed for the most part. Prestige and social selectivity are relatively unimportant at the acute-special hospitals, which, presumably selecting physicians according to the special medical function of the hospital, are more socially open. Minority-group affiliation also seems to be a stronger factor than prestige in determining the social composition of staffs of minority-group hospitals.

Career Contingencies as Life Chances

In this section we want to examine whether physicians with particular birthplace and medical school backgrounds have equal chances¹ of gaining access to different hospital-affiliation categories, or whether there are differential chances of access related to the prestige of the hospital category. The latter is what we would expect from the results of

¹As noted earlier we are only concerned with physicians located within the English-Montreal community at a point of time. We do not know how physicians with similar backgrounds who practice elsewhere have fared.

the previous section, however it is necessary to run the percentages another way for confirmation. We hypothesize that physicians do not have equal chances, and that those with background characteristics more readily assimilable to those of the charter community are more heavily represented in the prestigious categories, while physicians with "different" characteristics are more heavily represented in the less-prestigious categories.

Methodology

The data examined in this section are fully presented in Appendix D Tables D:5 and D:6. Tables D:3 and D:4 show over- and under-representations of physicians with particular birthplace/medical school backgrounds in relation to all physicians irrespective of such background. For the sake of brevity only important categories of birthplace/medical school were distributed according to category of hospital affiliation.

Tables 3 and 4 below present the data of Tables D:3 and D:4 in summary form. Only over- and under-representations of five percentage points or more are shown in Tables 3 and 4. In the analysis that follows we consider these two tables together, since each relates to all physicians in the particular birthplace/medical school category. Note that in these tables the two Jewish and two Catholic categories are combined.¹

For each birthplace/medical school category we will examine the patterns observable in Tables 3 and 4.

¹Data for each category are shown separately in Table D:5.

TABLE 3.--Summary table showing over- and under-representations (in percentage points) of physicians with particular birthplace/medical school backgrounds (compared to all physicians) by general-hospital category

Medical School	Hospital Category						N (100%)
	Major Teaching: G1 %	Partial Teaching			Non-Teaching: G5 %	Proprietary: G6 %	
		Jewish: G2A & G2B %	Catholic: G3A & G3B %	Other: G4 %			
Born in Quebec							
French Can.	-16	..	..	..	..	+32	120
McGill	..	+6	..	..	..	-5	512
Other Can.	..	+6	..	..	..	..	61
Foreign	-11	+6	..	..	..	+5	45
Born in Canada outside Quebec							
McGill	+16	-7	..	..	..	-6	140
Can. Outside Quebec	+14	..	..	..	..	-6	138
Born in Canada							
English C's	+26	+6	-6	-6	-6	-6	20
Non-Eng. C's	-18	+6	..	..	..	+9	33
Born in Foreign English Countries							
English C's	+12	-10	..	..	+6	-6	61
Born in Foreign Non-English Countries							
McGill	+6	-6	+7	..	..	..	40
Western E.	-13	..	+5	..	..	..	97
Eastern E.	-18	-11	..	+5	..	+7	96
Other Non-Eng.	-15	..	-6	..	..	..	22

(..) = less than 5 percentage points.

Abbreviations: Can.: Canada; English C's: English Countries; Western E.: Western Europe; Non-Eng. C's: Non-English Countries.

TABLE 4.--Summary table showing over- and under-representations (in percentage points) of physicians with particular birthplace/medical school backgrounds (compared to all physicians) by hospital-affiliation category

Medical School	Hospital-Affiliation Category									N (100%)
	Attending Physicians						Unaffiliated	Partial Affil. Only	Consulting Only	
	General Hos.: G1 - G6	Special Hospitals			Public Hos.: G7 & S6	Total (all attending)				
		Major Teach.: S1	Other Acute: S2 & S3	Chronic: S4 & S5						
%	%	%	%	%	%	%	%	%		
Born in Quebec										
French Can.	+8	..	..	..	..	+19	-7	..	-6	120
McGill	..	..	..	..	..	..	..	..	+6	512
Other Can.	..	..	..	..	..	..	+5	+7	-6	61
Foreign	-6	..	..	..	..	-7	..	..	..	45
Born in Canada outside Quebec										
McGill	..	..	..	..	..	..	-6	..	+6	140
Can.Outside Quebec	..	..	..	..	..	..	..	..	..	138
Born in Canada										
English C's	+8	+5	..	..	..	..	..	..	..	20
Non-Eng.C's	..	..	..	..	..	-5	..	..	..	33
Born in Foreign English Countries										
English C's	..	+8	..	..	..	+9	-5	..	-5	61
Born in Foreign Non-English Countries										
McGill	+8	..	..	..	..	+14	..	-5	-10	40
Western E.	-10	..	+5	..	..	-6	+13	..	-8	97
Eastern E.	-14	..	..	..	..	-12	+17	+5	-9	96
Other Non-Eng.	-21	..	..	..	..	-21	+28	..	-10	22

(..) = less than 5 percentage points.

Abbreviations: see Table 3.

Born in Quebec, Educated at French
Canadian Universities

These French Canadian physicians, not readily assimilable to English Montreal, are under-represented in the high-prestige major-teaching general hospitals, and over-represented in the lower-prestige proprietary hospitals. Their under-representation in the unaffiliated and consulting-only categories is due to our definition of "English-Montreal physicians."¹ We note in Table D:4 the smaller over-representation of these physicians in each of the special and in the public-hospital categories.

Born in Quebec, Educated at McGill

This is the most local category, native born and trained in the City. They have near average representation in most categories. They are over-represented at the Jewish General, which, we saw, is the most local operation. They are under-represented at the proprietary hospitals, and over-represented among the consulting-only, also a local category. Being locally born and trained, then, is not especially conducive to affiliation at one of the best hospitals, since presumably other factors such as ethnic origin, social class, professional achievement and sponsorship are also involved.

Born in Quebec, Educated in Canada
outside Quebec

There is average representation of these physicians except at the Jewish General, and among the unaffiliated and

¹If a physician has French preferred language and is not affiliated with an English-Montreal hospital he is by definition a French-Montreal physician and is excluded from the study.

partially affiliated where they are over-represented. We will observe a pattern emerge that those categories involving birth in Quebec or Canada and education outside Quebec or Canada are highly represented at the Jewish General. We can relate this to the large numbers of physicians in the Jewish community and their need to seek education elsewhere than at McGill.

It appears that these physicians,¹ perhaps because of their education outside Quebec, have difficulty in getting full staff privileges as they are over-represented among the unaffiliated and partially affiliated.

Born in Quebec, Educated at
Foreign Universities

These physicians,² with foreign school backgrounds, are under-represented at the major-teaching general hospitals and over-represented at the proprietary hospitals. We note that this category like the previous one is over-represented at the Jewish General. In Table D:4 we note that it is, expectedly, somewhat over-represented among the unaffiliated and partially affiliated.

Born in Canada outside Quebec,
Educated at McGill

In line with the association noted earlier between mobility within Canada and hospital prestige, we observe that these physicians are over-represented in the major-teaching

¹In Table D:2, sub-table "All English-Montreal Physicians," we note that these are mostly physicians from universities other than Toronto.

²In Table D:2 we note that these are mostly physicians educated in non-English countries.

general hospitals. They are under-represented in the proprietary hospitals and also at the Jewish General.

Born and Educated in Canada outside Quebec

Again we note association between mobility within Canada and hospital prestige. These physicians are over-represented at the major-teaching general hospitals and under-represented at the proprietary. The other categories have near average representation.

Born in Canada, Educated in Foreign English Countries

These physicians¹ are over-represented in the major-teaching general and special hospitals, which in contrast to the category born in foreign English countries, suggests a preference for graduates of foreign English universities. Possibly these universities are considered prestigious.² We note, again, an over-representation at the Jewish General. These physicians are under-represented in nearly all the other categories.

Born in Canada, Educated in Foreign Non-English Countries

This category shows representation converse to the previous one, which shows the differential chances of physicians with training in countries dissimilar to English

¹In Table D:2 we note that these are mostly physicians born in Quebec.

²Although not shown in Table D:2 an examination of computer output shows that half these physicians are educated in Britain.

Montreal. There is under-representation in the major-teaching general hospitals and over-representation in the proprietary hospitals. There is also, expectedly, over-representation at the Jewish General.

Born and Educated in Foreign
English Countries

An association is again observed between geographical mobility and affiliation with a prestigious category. These physicians are over-represented at the major-teaching general and special hospitals, and under-represented in the proprietary and unaffiliated categories. We note from the following non-English categories that only geographical mobility from the "right" countries is associated with prestigious affiliations. These physicians and the following categories are expectedly under-represented at the local Jewish General.

The non-teaching category also has an over-representation of these physicians, showing that not all mobile physicians with the "right" kind of background get into the prestigious practice settings. We might note in Table D:3 an over-representation of these physicians at the Catholic hospital, and that, compared to the Jewish General, there are more chances of a physician with foreign birthplace to be affiliated with the Catholic hospital.

Born in Foreign non-English Countries,
Educated at McGill

Again we find geographical mobility associated with the prestige of the hospital category, as these physicians are over-represented at the major-teaching general hospitals.

While we noted above that birth in Quebec and attendance at McGill does not especially lead to a prestigious affiliation, we find again that birth outside Quebec and attendance at McGill is associated with over-representation at the major-teaching general hospitals. Perhaps this is because only the very promising students from outside Quebec are accepted at McGill. These physicians are under-represented at the Jewish General which does not offer ready access to physicians born abroad. Conversely they are over-represented at the Catholic hospital.

Born in Foreign Non-English Countries,
Educated in Western Europe

This category, dissimilar in background to the charter English-Montreal community are under-represented at the major-teaching general hospitals and over-represented among the unaffiliated. They are expectedly over-represented in the Catholic hospital, and also at the lesser prestige other acute-special hospitals.

Born in Foreign Non-English Countries,
Educated in Eastern Europe

Like the previous category this one shows representation associated with category prestige. The physicians are under-represented among the major-teaching general hospitals, and over-represented among the unaffiliated, the partially affiliated, the proprietary and the other partial teaching hospitals. They are expectedly under-represented at the Jewish General.

Born in Foreign Non-English Countries,
Educated in Other Non-English Countries

These physicians are under-represented in the major-teaching general hospitals, and even in the Catholic hospital which depends as we have seen upon immigrant physicians. They are heavily over-represented among the unaffiliated. It is interesting to note in Table 4 among unaffiliated physicians that, as relative dissimilarity in background to the charter community increases, over-representation of these foreign non-English born physicians among the unaffiliated increases. Thus we move from no over-representation to over-representation of 13, 17, then 28 percentage points.

Summary

Our hypothesis has been confirmed for the most part. We have noted an association between ready assimilability of social background and high chances of having a prestigious hospital affiliation (and the converse), although the association has not been as strong as that seen in the section on characteristic careers. However, where the over- and under-representations are large enough to be noted, they are associated with relative prestige or with minority-group identifications. Where they are smaller they are usually associated with relative prestige in the direction indicated. The contrast is particularly strong among the major-teaching general hospitals, the most prestigious, and the proprietary and unaffiliated categories, the least prestigious.

While birthplace does not seem related to the practice of medicine, medical school presumably is. Although

foreign born and trained physicians and French Canadians are allowed to practice in the community, their chances of having a less-prestigious or no (except the French Canadians) hospital affiliation are relatively high, and their chances of having numerical strength in the lesser-prestige settings are greater. We wonder what are the implications of this for controls on quality of care rendered by physicians in different practice settings.

If we examine Table D:4 closely we note the expected differences between the major-teaching special and the other acute-special hospitals. However, we see that life chances are not as much associated with the acute-special hospitals as with the general hospitals. This confirms our earlier finding that hospital prestige and social background of physicians are not as important factors at the acute-special hospitals.

At the minority-group hospitals the over- and under-representations are not related to the hospitals' prestige. Rather they seem to be related to the structure of the minority-group community. Thus the Jewish General, a very local operation, does not offer high access to foreign physicians. The Catholic hospital offers easy access to foreign born and trained physicians, presumably because there are fewer physicians and more available beds, as well as many immigrants in the community.

CHAPTER VI

SUMMARY AND INTERPRETATION OF FINDINGS

Summary

Purpose

We sought in this report to replicate for English Montreal a study by David N. Solomon of Chicago physicians. Both studies focus upon broad social characteristics of physicians' careers in an effort to understand how these careers are shaped by the external institutions in which they participate and by their general social background. While Professor Solomon considered medical school, location of internship/residency and hospital affiliation, we focused upon birthplace, medical school and hospital affiliation in a similar search for typical career sequences.

There are 30 hospitals and 1,414 physicians in the study. Because the study is statistical it is not possible to make very definite interpretations of the data. However, the data do serve to describe in detail the community's hospital system and the way that physicians with different backgrounds are represented in different parts of the system. It would require further and more qualitative research to determine the detailed reasons for the phenomena we have observed and the meaning of these phenomena for the physicians concerned.

We studied the hospitals in categories and in setting them up we attempted to control for as many sociological variables as possible: for medical type of hospital (general, acute-special and chronic); for type of hospital affiliation (attending partial affiliation only, and consulting only); and for class of hospital if duplicate attending affiliation existed.

In order to assist the collection and analysis of data we set up three hypotheses. In examining the hospital system, we hypothesized that the hospitals would not be a homogeneous whole but would show marked ethnic/religious and class differences, differences that are presumably significant for the kind of careers centered upon these hospitals.

Then we considered the birthplace and medical school backgrounds of physicians by examining the characteristic careers and the life chances of physicians in different hospital categories. In considering characteristic careers we hypothesized that physicians with birthplace and medical school backgrounds readily assimilable to those of the British Protestant charter community of Montreal would be heavily represented in the high-prestige hospitals, while those of less readily-assimilable backgrounds would be more heavily represented in the lower prestige hospitals. In considering life chances of physicians, we hypothesized that physicians with birthplace and medical school backgrounds readily assimilable to those of the charter community would have greater chances of having a prestigious affiliation than would physicians with other social backgrounds. These hypotheses were based upon the findings of Professor Solomon's study of Chicago physicians.

Findings

In the main our hypotheses were confirmed. We examined how the hospitals differ in terms of sponsorship, formal approval, size, expenditures and endowments, and characteristics of their physicians--ethnic origin, specialization, professional activities, and office location. We assumed that these variables would serve to define the relative prestige of hospitals, and the differences among hospitals that are significant for physicians' careers.

We found that the general hospitals show considerable differences in these characteristics, and that they can be ranked according to relative prestige. These characteristics did not seem as reliable an index of the class of the minority-group hospitals, and we suggested that the most important prestige characteristic of these hospitals was probably their particular ethnic/religious identification. Apart from the latter hospitals, we found four rankings of general hospitals--the major teaching, partial teaching, non-teaching, and proprietary. The public hospital--lower in prestige--did not appear to fit this ranking system, and its most important characteristic seemed to be its purpose to serve a restricted population, mostly veterans.

In considering the special-hospital categories, we found a class ranking in terms of their hospital characteristics but not in terms of their physician characteristics. The high-prestige physician characteristics, found at some of the lower-prestige special hospitals, tended to conflict with the prestige ranking of special hospitals. We suggested that

because of the pattern of staff duplication, physician characteristics were not as reliable an indicator of hospital prestige among the special as among the general hospitals. We suggested also that hospital prestige may not be as relevant a factor to the careers of special-hospital physicians because of the nature of specialized practice, involving focus usually upon one range of conditions, and referral from primary-care physicians.

In Chapter IV we examined the pattern of staff duplication and concluded that it ought to be controlled for in order to understand the sorting of physicians into the hospital system. We, therefore, set up categories that assign the physician with multiple attending affiliation to only one of the hospital categories. And we employed these new physician/hospital categories in examining the sorting of physicians into the hospital system.

We found that birthplace and medical school are contingencies in physicians' careers in the sense that they affect where the physician is located in the hospital system. Thus, in examining characteristic careers in hospital categories, we found positive association between prestige of the category and homogeneity of physicians in terms of birthplace and medical school. As we moved down the ladder of relative prestige we found increasing heterogeneity in background or, in the case of the proprietary hospitals, an increase in physicians with backgrounds not readily assimilable to those of members of the charter community.

The minority-group hospitals did not have career sequences that could be identified with their prestige. The career sequences of their physicians seemed to be related more to the nature of the particular minority-group community, such things as the ratio of physicians to population within the community, the availability of beds and patterns of immigration.

The acute-special hospitals did not show career sequences related to the prestige of the category as much as did general hospitals. This again suggests there is something in the nature of specialty practice that allows the special hospitals to be more socially open compared to similar general hospitals.

Although we did not anticipate it, we found that geographical mobility across Canada is associated with the prestige of the hospital category. Thus we found greater representation of physicians born and educated in Canada outside Quebec in the higher-prestige hospitals.

In considering life chances of physicians we found that physicians with birthplace and medical school backgrounds readily assimilable to those of the charter community have greater chances of gaining a prestigious general-hospital affiliation. While physicians with "different" backgrounds have higher chances of gaining affiliation at a lesser-prestige hospital category or of having no affiliation.

Again, for minority-group hospitals, we found that the pattern of over- and under-representation was more closely associated with the characteristics of the minority-group

community than with the prestige of the hospital. For acute-special hospitals we also found a much less pronounced association of life chances with the prestige of the hospital category.

We found that physicians, mobile either in that they came to Quebec prior to their medical education or after it, were more highly represented at the high-prestige major-teaching general and, in some cases, special hospitals.

Interpretation of Findings

Career Contingencies

We have shown to what extent the hospital categories differ among themselves in prestige. We may safely assume that these differences influence the careers of physicians at the various hospital categories. Hall's and Solomon's interview data from hospital physicians, for example, have shown to what extent power within the profession and types of careers are associated with different classes of hospitals.¹ Hall, in studying medical practice in a community of 250,000 population, found that the "inner fraternity" which exercises effective informal control of the medical profession is comprised mainly of physicians affiliated with the most prestigious hospitals. At the same time he found that the main orientations of their careers differ among physicians affiliated at different hospital categories. Thus the elite

¹Hall, "The Informal Organization of the Medical Profession," and "Types of Medical Careers"; Solomon, "Career Contingencies of Chicago Physicians."

hospitals comprise physicians whose main career orientation is towards the esteem and cooperation of their colleagues. The other hospitals comprise physicians whose orientations are either to their individual practices and competition among physicians--the individualistic type--or to establishing relationships of friendship and loyalty among physicians and patients--the friendly type.¹ Solomon tested this initial formulation by studying physicians in a larger city.² He found the colleague-type career concentrated in the elite Protestant hospitals and the individualistic and friendly types in the less prestigious hospitals.³ He confirmed that the essential differences between the types is in "the direction in which their loyalties flow. The colleague type is loyal to an institution, the individualistic type to himself, although many of these expect from their patients a loyalty which they probably reciprocate, while the friendly type is loyal to other persons, namely the members of the immediate clique with which he cooperates."⁴

We may assume that these contrasting career orientations are also present among the physicians of the different

¹Hall, "Types of Medical Careers," pp. 246-53.

²Solomon, "Career Contingencies of Chicago Physicians," pp. 71-135.

³Solomon also found that the hospital categories (especially the high-prestige and the other non minority-group hospitals) differed in the pattern of referrals, obtaining access to hospital facilities, and in obtaining and retaining patients.

⁴Ibid., p. 150.

hospital categories in this study. However, among the general hospitals, the main contrast is probably between the major-teaching, and the non-teaching and proprietary. Probably the three types of careers are well represented in the other hospitals. It might be instructive to examine the special-hospital physicians to find out whether the same range of career types is found there. We would suggest on the basis of the lesser importance of prestige at these hospitals and their more socially-open nature, that there would be much greater representation of colleague-oriented careers than among the general hospitals. Hospital affiliation thus appears to be a major contingency in the careers of physicians.

We have found that birthplace--signifying national and linguistic origins--and medical school--signifying type of professional socialization--affect the type of hospital affiliation gained by a physician, and the proportion of physicians with like backgrounds with whom he will be associated. These also, therefore, are contingencies affecting the outcome of physicians' careers.

Sponsorship

While we have observed a pattern of sorting of physicians into hospital categories that depends in part upon physicians' birthplace and medical schools, we are not able to give the reasons for this. However, other students of medical sociology who have explored this question through interviews with physicians have emphasized the importance of sponsorship in the process of gaining access to prestigious

hospital facilities.¹ Solomon has shown that the process of sponsorship begins at least at medical school, and that it assists the physician to gain a preferred internship or residency and later a prestigious hospital affiliation:

While sponsorship is probably necessary to various stages of the career, it is most effective and most important towards the beginning. In medical school one needs to be assured of obtaining the appropriate internships, and during internship and residency the young physician must be thinking about the initiation of practice.²

We would assume that this process of sponsorship of neophyte physicians by those well established is also highly operative in the sorting of physicians onto the staffs of the high prestige hospitals in this study. Although here also we suggest it is much easier to get sponsorship within the special hospitals than within the general. Perhaps the factor of financial competition is not as important among physicians working in special as in general hospitals.

Organizations and Main Tasks

The differences we noted, between general, acute-special and chronic/convalescent hospitals in physician and hospital characteristics suggest that a neglected dimension in the application of concepts like prestige to organizations is the nature of the major task carried out within the organization. It would seem from our data that these differing tasks influence the meaning and importance of the organization's prestige, and have a significant bearing on types of

¹Hall, "The Stages of a Medical Career," and Solomon, op. cit.

²Ibid., p. 97.

careers found among the organization's personnel. Differing tasks ought not to be ignored, therefore, in studies of hospitals as organizations and of hospital personnel.

Hospitals in Sociology and Economics

There appears to be a tendency for discussion of the economics or the political-economy of medical care to consider organizations (like hospitals), wherein services are provided, as homogeneous. Class differences among these organizations are not considered particularly relevant to a study of the allocation of resources to meeting consumer demand.

However, it appears that our data do have implications concerning the question of physician-manpower supply, possible differences in quality of care that accompany differential hospital prestige, and the control and allocation of funds for medical education and for research.

It is not merely "hospitals" that require "medical manpower." Evidently it is different classes of hospitals that gain physicians with various social backgrounds. It would seem that who achieves or fails to achieve access to hospital facilities has a bearing on costs under a medical insurance program, since so much of total physicians' services are provided in hospitals. When we depend to a large extent on foreign physician manpower, and when we assign them greater power in the lesser-prestige practice settings, this may have implications for our ability to continue attracting large numbers of immigrant physicians.

We might raise the question whether, when so many highly trained personnel are centered within the elite hospitals, there may not be important differences in quality of care between the higher-prestige and the lesser-prestige hospitals.

Our data, then, seem to have something to suggest about questions usually considered matters of "medical economics." Perhaps this study will support the need for the viewpoint of sociology in the multi-disciplinary approach to social issues and policy that many social scientists are calling for today.¹

Further Research

Career Choice and Staff Selection

Because of the lack of qualitative data it has not been possible to determine to what extent the sorting patterns we have observed are due to the choosing of particular hospitals by physicians, or the selection of particular physicians by hospitals. Presumably both factors are at work.

In view of the importance of hospital affiliation to physicians careers and the major differences between hospital categories, it would be useful to determine to what extent both these factors operate. This would require intensive interviews with physicians in different hospital categories, and would improve our knowledge of the process of entry of professional personnel into institutions.

¹See for example, Mancur Olson, Jr., "Economics, Sociology, and the Best of All Possible Worlds," The Public Interest, No. 12 (Summer, 1968), pp. 96-118.

It would be instructive to study this process among native born and trained physicians, among those born and trained in English and in non-English countries, in order to see whether the pattern of access to hospitals differs among these various national and linguistic categories. This would have a bearing on the assimilation of foreign physicians into the English-Montreal medical system.

Such a study could also focus upon the process whereby physicians come to be on staff in different practice settings. An example would be the 30 public-hospital physicians who are employed mainly on salary, in a restricted setting unlike the usual entrepreneurial private office. An alternative would be a study of the 6.4% of attending physicians (64) whose only form of remuneration is salary as opposed to fee-for-service payments (see Appendix G Table G:8).

Other Contingencies

Studies of career contingencies have usually focused upon broad sociological variables, such as institutional participation. However, it seems certain that many other variables are operating that we do not know much about. Among these would be counted social class of the prospective physician's father, performance at medical school, assessment by supervising physicians during internship/residency, family and personal contacts within the profession, and participation in various informal physicians' organizations such as fraternities. Studies of career contingencies could be broadened by considering more intensive factors such as the above, in relation to

where in the system of medicine the physician is located.

Appendix G Tables G:1 to G:8 show a range of variables that are differentially associated with types of hospital affiliation and may also be considered as contingencies affecting the outcome of physicians' careers.

The Power Elite

We have considered attending physicians as a whole. However there are gradations among attending physicians (see Appendix A Hospitals section, "Attending Physicians"). As John Porter has shown, social class is better indicated by the power held by persons rather than by education, occupation or income.¹ Attending physicians, thus, are not identical in the power they hold. The chiefs of departments and senior physicians hold most power among physicians. Presumably a study of the social origins of this power elite among attending physicians would yield findings, similar to those of Porter on the economic elite, showing even more homogeneity than among the total attending staff. Although the Reddy Memorial, for example, is relatively heterogeneous in the ethnic origin of its physicians (Appendix B Table B:7), a look at the list of attending physicians by name indicated to the author that most of the senior staff positions are held by English and Scottish physicians. It would be profitable, therefore, to examine the social homogeneity of the more powerful physicians in the various hospital categories.

¹The Vertical Mosaic, op. cit., and J. Porter, "The Future of the Upward Mobility," ASR, Vol. 33, No. 1 (February, 1968), pp. 5-19.

Multiple Affiliations

There is a sociometrical aspect to the fact of multiple attending affiliations. Being chosen as attending staff is in a way similar to the positive choices, and multiple staff affiliations resemble multiple choices in sociometrical studies. It might be profitable to inquire into the backgrounds and characteristics of physicians who have been chosen by more than one hospital, as compared to those with only one affiliation. Data on characteristic careers of physicians with attending affiliation at a general and an acute-special hospital are presented in Appendix D Table D:10.

French Canadian Physicians

A recent study has examined in great detail the relative differences in professional advantages between the French-speaking and the English-speaking sectors of the Montreal medical profession.¹ The advantages of the English-speaking sector were numerous and included more physicians per population, more beds per population and per physician, more attending positions per physician, more specialization among physicians, more involvement in medical education, and greater centralization of physicians' offices. Along with this, Demers noted the extensive segregation of physicians of the two linguistic groups. He wondered about the seeming and relative inability of French-speaking physicians to gain admittance to the English hospital system. His conclusions were balanced, and he recognized that the reasons for this

¹Demers, op. cit.

linguistic segregation may be due to a variety of factors and to tendencies among both communities.¹ However, he found there was an "inégalité des ressources disponibles et nécessaires au développement de chaque système hospitalier."² He observed that, "une forte ségrégation ethnique au niveau du personnel médical de chaque sous-système hospitalier empêche les médecins français de bénéficier des avantages institutionnels du groupe anglais."³ And he concluded: "Mais il faudrait un rare degré d'ignorance des inégalités des moyens institutionnels entre ces deux groupes pour que les médecins français ne prennent pas, à un moment ou à un autre, ombrage des privilèges trop manifestes des médecins anglais."⁴

In view of the ease with which the observation may be made of inequality of advantages between the two linguistic groups and of the strong segregation between them, it would be profitable to study the careers of those French Canadian attending physicians who are affiliated with an English Montreal hospital. This would aim to understand the processes of accommodation and assimilation through which physicians from one of the linguistic groups are accepted into the hospital system of the other.

¹Ibid., pp. 92-98.

²Ibid., p. 96.

³Ibid., p. 94.

⁴Ibid., pp. 96-97.

Presumably social pressures will become greater for more openness of the English hospital system to French-speaking physicians. If this course of action proves desirable, such a study might assist it. We could note that, of the 1,008 attending physicians in this study, 8% have French preferred language, 13% have French ethnic origin, and 12% are graduates of French Canadian universities. Physicians of French ethnic origin comprise 10% of all 1,414 physicians in the study (see Appendix B Table B:20).

APPENDIX A

EXPLANATION OF TERMS

APPENDIX A

EXPLANATION OF TERMS

Physicians

College of Physicians and Surgeons
of the Province of Quebec

The Quebec College is the governing body of the medical profession in the Province, authorized--under an Act of the provincial legislature¹--to license qualified persons to practice medicine, surgery or obstetrics in Quebec; to discipline its members in professional non-criminal matters; and to participate, with representatives of provincial medical schools, in examination of candidates "for the practice of medicine," (in effect for the M.D. degree).² Through its Provincial Medical Board the Quebec College appoints examiners for specialty examinations and issues specialty certificates to successful candidates.³

Ethnic Origin

This was determined by a Quebec College question asked of physicians on its 1964 questionnaire:

"Ethnic Origin: French; English; Scottish.....;
Irish; Other (specify)....."

¹Quebec, Revised Statutes (1964), C. 249, "An Act Respecting the Medical Profession."

²Ibid., sections 43, 61 and 37. The Quebec College has not issued a schedule of medical and surgical fees since its 1959 amendment of the 1952 schedule. There is some thinking in Quebec that fee setting is a syndicalist function properly belonging to the provincial Federations of general practitioners and specialists rather than to the College.

³Quebec College, The Law and Regulations Relating to the Granting of Certificates of Qualification to Specialists and Requirements for Certification in the Various Specialties (July, 1966).

Physicians licensed after this date were asked their ethnic origin at time of registration. Officials of the College reported that, where there was no response to this question, the data were provided by physician-officials of the College with wide personal knowledge of Quebec physicians.

In discussions at the Quebec College, its understanding of "ethnic origin" appeared to parallel that of the Canadian Census: "To what ethnic or cultural group did you or your ancestor (on the male side) belong on coming to this continent?"¹ "The question regarding ethnic origin in the Census is an attempt to distinguish groups among the population having similar characteristics based on a common heritage."²

Because in the 1961 Canadian Census of metropolitan Montreal, the number of Jews by religion (102,724) was 40.60% greater than the number of persons reported Jewish by ethnic origin (73,062) (see Appendix E Table E:1), we thought perhaps a similar problem might exist in regard to our own data. For example, as Appendix B Table B:20 shows, there are 1.84% (26) of English Montreal physicians who are reported Jewish by religion but not by ethnic origin in the Quebec College's data (the data on religion, however, were complete only for the 141 physicians licensed between 1964 and April 1967--see Appendix B Table B:7). We wondered, therefore, whether our Jewish-by-ethnic-origin also understates the number of physicians who are members of the Jewish community in Montreal. We checked our figures with Mr. Louis Rosenberg, Research Director of the Canadian Jewish Congress. He very helpfully reported that the DBS Census Branch made a special computer run at the request and expense of the Canadian Jewish Congress (CJC) which showed there were 475 physicians and surgeons Jewish by religion in metropolitan Montreal in 1961 (290 Canadian born and 185 foreign born).

How reconcile this with our figure of 245 physicians Jewish by ethnic origin (figure derivable from Appendix B Table B:20)? First of all we might increase the 245 by 40.60%--assuming a situation similar to that in the 1961 census --which yields an estimate of 344 physicians Jewish by religion in metropolitan Montreal in 1967. On the other hand we ought to subtract from the CJC figure, retired physicians, residents and interns and Jewish physicians members of the French-Montreal medical community. The latter might have numbered between 14 and 22 in 1964.³ Also, since there are very large

¹Canada, DBS, 1961 Census of Canada, Enumeration Manual (Form 60).

²DBS, Census Branch, quoted in a letter to the author from Mr. Louis Rosenberg, Research Director, Canadian Jewish Congress.

³Derived from Guy Demers, op. cit., p. 81 Tableau 24, and p. 47 Tableau 11.

numbers of interns and residents in English Montreal (see footnotes to Chapter II), we might assume that the difference between our estimate of 344 physicians and a hypothetical 1967 Census count of physicians Jewish by religion--something in excess of 131 (475-344)--is made up of retired and French-Montreal physicians, and interns and residents. Physicians, therefore, who should properly be excluded from the study.

We sought another estimate by asking whether the number of Jewish General Hospital attending physicians reported as Jewish by ethnic origin or, for some, by religion only, understates the number who are members of the Jewish community. Mrs. Freda Paltiel, Senior Research Officer, Department of National Health and Welfare, very kindly read over the names of Jewish General attending physicians and suggested that the proportion who are members of the Montreal Jewish community is probably higher than the 60.31% that our data show (see Appendix B Table B:7) though less than 90%. Following this line of thinking through, yields an estimate of between 325 (using 80%) and 367 (using 90%) Jewish physicians in our study, instead of the 271 (19.17%) shown in Appendix B Table B:20.

General Practitioners

In this study they are taken to be physicians who do not have a specialty certificate from the Quebec College or Royal College. Some of these may be confining their practice to a specialized area of medicine, however.

Specialists

In this study they are taken to be physicians who have a Quebec College or Royal College specialty certificate. Excluded are physicians who have American specialty board certificates, although the latter would presumably consider themselves "specialists." Included are certificated physicians who are engaged in general practice. Specialty certification in this study is considered as it affects the physician's access to hospital facilities and defines the prestige of hospitals. It also affects a physician's earnings, since in many provinces physicians who are practising their specialty may charge higher fees than GP's for the same services, and of course, may charge higher fees for consultations.

Medical insurance agencies may help to control fees since they may establish their own schedule of payments, or they may not pay, for example, specialist rates to a certificated physician if he is engaged mainly in general practice. Since Quebec ranked in 1964--before its Medical Assistance Plan started in 1966--among the provinces with the lowest proportion of their population having insurance for

comprehensive medical benefits,¹ this third-party-payment control factor may perhaps become more important in this province: "Cette pression sera d'autant plus forte que le public ne sera pas satisfait de la protection offerte par les compagnies privées. Or nous savons qu'il y a beaucoup de mécontentement de ce côté. Contrairement à leurs confrères des autres provinces, les médecins du Québec n'ont pas d'entente avec les assureurs et ne sont pas tenus de s'en tenir aux tarifs établis par leurs associations professionnelles. Dans un grand nombre de cas, l'assuré doit ajouter à une prime déjà relativement élevée un dépassement d'honoraires substantiel."²

We might note that the Quebec College does not strictly consider physicians with only Royal College certification to be specialists.³ We might speculate on how this affects the careers of the 59 physicians in our study with this standing. Possibly, due to the autonomous nature of the English Montreal medical system, this is overlooked, although the potential conflict in this kind of situation is suggestive. Does it affect these physicians' billing practices, for example? It does not seem to affect their hospital affiliations since they are represented in most categories (see Appendix B Tables B:8, B:17 and B:21).

Types of Hospital Affiliation (including unaffiliated)

See Hospitals section below, "Types of Medical Staff in Hospitals."

Hospitals

Hospital

This study includes all English organizations listed as "hospitals" by DBS: "A hospital is defined as an institution which is operated for the medical, surgical, and/or obstetrical care of in-patients and which is licensed or approved as a hospital by the federal or a provincial government, or by a

¹Canada, DNHW, Research and Statistics Division, Persons Covered under Medical (i.e. Physicians'-service) Insurance and Out-of-hospital Prescribed-Drug Insurance, Canada and Provinces, 1964 (July, 1965).

²La Fédération des Médecins Spécialistes du Québec, Bulletin d'Information (Montréal: le 1er février 1968).

³Quebec, Revised Statutes (1964), op. cit., sections 83 to 86.

municipality acting under provincial law."¹ Excluded are "related institutions" such as infirmaries, nursing homes, rest homes, homes for the aged, the blind or the senile. All English hospitals shown in the other important listings are included in this study.² Three institutions included by Demers³ were not considered hospitals because DBS lists two as related institutions and does not list the third (Hasle Nursing Home, House of MacGregor, and Woodpine Village Convalescent Home).

Types of Hospitals

The following explanations relate to how the terms thus defined were used in this study to classify hospitals.

Since our focus was on hospitals as locales of physician practice, we classified those as "general" in which a majority of beds were so classified by the Canadian Hospital Directory (CHD),⁴ and those as "special" in which a majority of beds were shown in the same source as reserved for some special purpose: for a particular condition or type of service, and/or for the practice of some medical specialty or narrow range of specialties. The definitions below of general and special hospitals explain the meaning of the terms "general" and "special" above.⁵

¹Canada, DBS, List of Canadian Hospitals and Related Institutions and Facilities, 1966 (Ottawa: Queen's Printer, 1967), p. 3 and pp. 17-29.

²See Canada, DNEW, Research and Statistics Directorate, Listing of Hospitals, Related Institutions and Facilities Included in the Provincial Agreements under the Hospital Insurance and Diagnostic Services Act for the Year 1966 (Ottawa: March, 1967); and Canadian Hospital Directory, 1966 (Toronto: The Canadian Hospital Association, 1966).

³Guy Demers, op. cit., pp. 132-36.

⁴Op. cit., pp. 19-20.

⁵Except that our pattern of inclusion and exclusion differs as follows from that of DBS and the CHD. For their statistical purposes a children's hospital is counted among the general, whereas we have included the Montreal Childrens with the "special." We include the Catherine Booth with special hospitals as does DBS; the CHD classifies maternity hospitals as general. We include the Royal Edward among the special; although both DBS and the CHD include chest-condition hospitals with the general. We include the Douglas hospital among the special as does the CHD; DBS treats mental hospitals separately from both general and "allied special."

General Hospital

"A hospital which provides for the treatment and care of all types of diseases or at least a wide range of conditions."¹ This comprises active treatment of acute medical and surgical conditions and obstetrical care.² A general hospital nearly always has separate departments of medicine, paediatrics, obstetrics and gynecology, surgery and psychiatry--the "basic departments."³

Special Hospital

DBS defines special hospitals ("allied special") as including chronic and convalescent, rehabilitation, and maternity hospitals, and "a hospital which primarily provides for the treatment of a particular type of disease, condition or case such as communicable disease, orthopaedic, neurological and cancer; a hospital which provides for a combination of various types of service which cannot be classified into chronic, convalescent or rehabilitation."⁴ In addition to the hospitals that DBS counts with the special, we have as already noted included the childrens, chest-conditions and mental hospitals.⁵

Acute Special.--Our thinking here was to classify those special hospitals as acute special in which the patient enters for active medical care over a short term. While the Douglas (mental) hospital does not meet this latter criteria, it seemed more appropriate to classify it with the acute special than with the chronic/convalescent (chronic) hospitals⁶ since,

¹Canada, DBS, Hospital Statistics 1964, Vol. I: Hospital Beds (Ottawa: Queen's Printer, 1966), p. 9.

²CHD, op. cit., p. 19.

³Oswald Hall, "The Informal Organization of Medical Practice in an American City," op. cit., p. 179.

⁴Canada, DBS, loc. cit., p. 9 and p. 10.

⁵These three hospitals are also classified with the "special" type of hospitals in Canada, DNEHW, loc. cit., pp. 9-14, and Malcolm T. MacEachern, Hospital Organization and Management (3rd ed. rev.; Chicago: Physicians' Record Co., 1957), pp. 1123-70.

⁶Mental illness is usually classified as a chronic condition. See U.S.A., Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, Current Estimates from the Health Interview Survey, United States--July 1966-June 1967 (Washington: January, 1968).

unlike the latter, it is restricted to a particular type of disease, for which medical treatment is usually provided by one specialty--psychiatry. Perhaps the term "active treatment" would have been more appropriate than "acute." Although the degree of active treatment must vary between, say, the Neuro and the Douglas and Catherine Booth.¹

Chronic/convalescent (chronic).--"Hospitals which primarily provide for the treatment of conditions requiring long-term care or for treatment of patients who are considered to be in the recovery stage of an illness, especially where this is a long-term process."² They are dealt with as a separate category in the study (procedure followed by DBS) because they involve much less "active" medical treatment than do the general and acute-special hospitals. Compared to the latter two types, chronic hospitals provide proportionately (to patients) less nursing care; less surgical operations; less professional hours in pharmacy, laboratory, radiology, physiotherapy, and out-patient care; less professional hours in medical records and medical library, nursing education, medical education and social service.³

There does not always appear to be a great difference at present, except in definition, between chronic and convalescent hospitals, though the former usually have more organized medical departments and medical treatment facilities. In practice some chronic hospitals take convalescing patients and some convalescent hospitals take patients with long-term conditions; and the concept of "extended care"⁴ seems to be breaking down even more the distinction between the two, although this type of facility is evidently in short supply. Because of their similarity, therefore, both these types are considered together in this study.

¹At the Neuro discharged patients have spent an average of 19 days in hospital; at the Douglas 45% of discharged patients have spent from 3 months to several years; at the Catherine Booth, 56% of adult patients are obstetrical cases, and 72% of these are spontaneously delivered--hardly an acute medical condition. See annual reports of the hospitals for 1965.

²Canada, DBS, loc. cit., p. 9.

³Idem, Hospital Statistics 1964, Vol. VII: Hospital Indicators (Ottawa: Queen's Printer, 1966), pp. 92-133.

⁴Interviews 6, 13 and 17.

Ownership of Hospitals

Voluntary Hospital

One that is owned and maintained by a non-profit corporation (called "public" by DBS). That is, it does not exist for the pecuniary gain of its shareholders. It may be created by an Act of the provincial legislature, by letters patent under the non-profit-companies section of the Companies Act, or by some other public document.¹ No member of the board of management may be remunerated in connection with his hospital duties.²

Proprietary Hospital

A hospital owned by a single proprietor, a partnership or a group of shareholders (called "private" by DBS). Like the voluntary, it must be licensed by the Quebec government; unlike it, the proprietary hospital's owners are allowed to retain any profits accruing from the hospital's operation. However, proprietary hospitals participating in the provincial hospital insurance program (4 of the 5 in this study) are limited in the amount they may charge--over and above the "standard ward" rate that is paid to the hospital by the government on behalf of all patients--directly to patients in semi-private and private rooms.³ On the other hand they may have 80% of their beds classified as semi-private and private whereas public hospitals may only have 60% so classified.⁴

Four of the five proprietary hospitals mostly serve French-Canadian patients;⁵ the fifth--Mayfair--presumably does not since it is located in an English speaking area of the City (see Appendix E Maps 2 and 5 and Table E:4).

¹Quebec, Revised Statutes (1964), c. 271, "Companies Act," Part III: "Corporations or Associations Having No Share Capital, Incorporated by Letters Patent."; Quebec, Legislative Assembly, Bill 44, 11 Elizabeth II, c. 44 (1962), "Hospitals Act" (Revised to 1965), section 1,d.

²Ibid. (Hospitals Act), section 12.

³Québec, Chambre du Conseil Exécutif, Arrêté en Conseil No. 1686 (le 22 juin 1967).

⁴Ibid.

⁵Information secured from the hospitals' administrators.

The Bellechasse Hospital.--Guy Demers (op. cit.) following information from the provincial government, classified this as a French hospital. From one point of view it is: located in an overwhelmingly French area, with mostly French patients, physicians and nurses. We have, however, classified it as English since it is owned by English-speaking Montrealers, 4 of 6 major medical-department heads are English speaking, and 13 of 27 attending specialists in medicine and surgery are English speaking. At the other three proprietary hospitals with attending staffs, a majority--50% in one case--of physicians are English speaking.

Public Hospital

Owned directly by government (called "federal" by DBS, which includes hospitals owned by a province or municipality with its "public" category). The Department of Veterans Affairs owns both these hospitals in the study. They provide services to persons whose health care is a responsibility of the federal government: veterans in receipt of disability pensions, veterans in receipt of War Veterans' Allowances, other veterans who are indigent, members of the armed forces and the RCMP, merchant seamen, and foreign students studying in Canada under its foreign aid program.¹

Open and Closed Hospitals

Because we were focused, in this study, upon access to hospital facilities, we had to consider whether being included or excluded from a hospital's medical-staff list was indeed significant for a physician's career. Can the physician with no formal affiliation still practice in hospitals under some sort of informal relationship; or is the "unaffiliated" physician really excluded from hospital facilities? The terms traditionally applied to this situation are "open" and "closed."

We asked the hospitals, therefore, to what extent physicians not on their lists--either as consulting, attending, partially affiliated (visiting, courtesy etc.), or honorary staff--could admit and treat their private patients at the hospital (see Appendix F Item 4). According to this understanding of the term, the responses showed that all voluntary general and acute-special hospitals and the two public hospitals are closed. The three smaller proprietary hospitals, and the three Christian convalescent hospitals (see Appendix B Tables B:1 and B:11), are open. Thus "unaffiliated" physicians are excluded from practising in virtually all the English hospital system--and presumably from the French system as well. Similarly "partially affiliated" physicians are excluded from hospitals except those where they have partial affiliation.

¹Canada, Veterans Treatment Regulations, Orders in Council 1962-1401, and 1965-1745; and interviews 5 and 17.

For our purposes, then, we were able to indicate to what extent the lists of physicians are significant and whether the individual hospitals are "open" or "closed" to other physicians.

In interviews and readings the author noticed some confusion in the usage of these terms, however. One writer defines:

An 'open' hospital is one in which there is an attending or active medical staff responsible for the treatment of charity cases, but in which other physicians--generally known as the courtesy medical staff--are permitted to utilize the private room facilities, provided there is full compliance with the rules and regulations of the institution . . .

A 'closed' hospital is one in which all professional services, private and charitable, are provided and controlled entirely by the attending or active medical staff. No other physicians are permitted to treat patients in the hospital except under consulting agreement with members of the medical staff and approval of the governing board.¹

According to this slightly different definition, 7 of the voluntary-general and 2 of the acute-special hospitals--said to be "closed" above--may be considered "open" hospitals since they have some form of courtesy or visiting staff (see Appendix C Tables C:2 and C:3).

We should note that many or perhaps most hospitals may grant "temporary" privileges to a physician under certain conditions--accidents and emergencies for example. However, such a physician is usually restricted in some way, for example in the number of patients he may treat, or in having to work under direct supervision of an attending physician.²

Teaching Hospital

Like most institutions hospitals strive to present a good public image, and to apply prestigious terms to themselves. There seems to be a tendency for a hospital with any connection to a medical school--having a faculty member

¹Malcolm T. MacEachern, Hospital Organization and Management (Chicago: Physicians' Record Co., 1957), pp. 169-70.

²Based on a reading of the medical-staff by-laws, rules and regulations of the Lakeshore General, Montreal General and St. Mary's hospitals. Full citations are given in the Bibliography, unpublished material section.

as chief of a department for example--to imply it is a "teaching hospital." Since a resident is a physician studying and practising in a hospital in order to become a specialist, any hospital that has residents may think of itself as a teaching hospital since its attending physicians are supervising and presumably teaching the residents. So, as with most social categories, there is difficulty in defining this term.

The difficulty is compounded by several factors. Since the medical school is engaged in teaching students and not defining categories, understandably its officials seem uncertain sometimes of the exact standing of particular institutions. Its documents too are a little contradictory. Also, social change complicates the picture since the formal relations between McGill and the English hospitals are under review.¹ However, there is no argument about which hospitals occupy center stage in medical teaching: The Montreal General and Royal Victoria are the major-teaching general hospitals; the Childrens and Neuro are the major-teaching special hospitals.

We have followed this usage of "teaching hospital."² Since the term appears essentially connected with the teaching of undergraduate medical students,³ we have classified, for the purposes of Chapter III and Appendix B, all hospitals that regularly teach undergraduates as "teaching" (Tables B:3 and B:12) if McGill so considers them; with "major teaching" restricted to the four mentioned above. We use the terms "other teaching" and "partial teaching" (Table B:11) to signify the three special hospitals⁴ that teach medical undergraduates. We have classified as "non-teaching" (Tables B:3 and B:12) those hospitals that do not teach undergraduates or that do a small amount of such teaching but are not considered teaching hospitals by McGill. We have classified as "associated" hospitals (Tables B:2, B:4 and B:13) those that McGill so describes. Association means some or all of a hospital's

¹Interviews 7 and 20.

²Based on official documents of McGill's Medical Faculty and interviews 7 and 20.

³A teaching hospital is one "where undergraduates are continually receiving instruction in general medicine, surgery, obstetrics or paediatrics." Kenneth F. Clute, The General Practitioner (Toronto: The University of Toronto Press, 1963), p. 45.

⁴Called "specialty hospitals" by McGill. McGill University, Faculty of Medicine, "Form to be filled in by all residents and fellows."

departments are directly approved by the Medical Faculty for graduate training of physicians (mostly residents and fellows) proceeding to an advanced degree from McGill (Diploma, M.Sc. or Ph.D.), or taking a residency program directed by the Faculty.¹ All but one teaching hospital is also an associated hospital.

To some extent the associated hospitals called, "non-teaching" in Chapter III and Appendix B, may be thought of as "partial" teaching hospitals. And for the purposes of Chapter V and Appendix D--to distinguish them from hospitals that have direct university approval for neither undergraduate nor graduate teaching--they are so described (Tables D:2 to D:6). Similarly, in Appendix G, the "non-teaching" hospitals directly associated with McGill are included with the partial-teaching special hospitals in the category, "partial-teaching only."

Speaking of the four major teaching hospitals, the Queen Mary and three partial teaching special hospitals, the Medical Faculty writes: "[They] are at the disposal of the teaching staff and students for clinical and pathological study. . . . The staffs of these institutions are appointed with the co-operation of McGill University and, for the most part, are teachers in the Medical Faculty."²

Types of Medical Staff in Hospitals³

Attending Physicians

These are the physicians responsible for running the medical affairs of a hospital. This includes supervising the provision of medical services; maintaining standards of medical care; organizing functions among physicians; providing

¹Ibid., and interviews 7 and 20. We say "directly" because the Catherine Booth and Shriners hospitals, though not considered associated hospitals by McGill, have partial residencies presumably in conjunction with an associated hospital (see Table B:13).

²McGill University, Faculty of Medicine 1966-1967 (Montreal). At 7 of these hospitals the Dean of the Faculty of Medicine is ex officio a member of the board of management. Presumably no such formal office-sharing exists at the government-owned Queen Mary's.

³This discussion is based on interviews with attending physicians (see Appendix F Item 5); and a reading of the by-laws, rules and regulations of the Lakeshore General, Montreal General and St. Mary's hospitals, cited in full in the Bibliography. See also C. Wesley Eisele (ed.), The Medical Staff in the Modern Hospital, op. cit. Many other sources already cited deal with physicians in hospitals.

services to "public" (charity) patients and to patients who do not already have their own physician among the attending staff; and carrying out the medical education activities of the hospital.

They may hold office on the Medical Board and the medical committees (although some offices may be reserved for higher ranks of attending physicians), and may vote in electing medical-staff officials and deciding matters that concern the medical staff. The hospital's medical board is chosen from among these physicians. They may admit and treat their private patients, and they have first call on the hospital's available beds.

In return for these privileges attending physicians assist with the treatment of public patients in the hospital's wards (usually for a certain number of days or half days each month); teach and supervise interns and residents--and teach nurses in some cases; teach undergraduate medical students at the teaching hospitals; and sometimes treat public patients in the out-patient and emergency clinics. They usually must attend meetings of the medical staff and its committees, and are expected to take an active interest and participation in the hospital's medical business. The attending staff is usually divided into several ranks. At the Montreal General, for example, the terms used to distinguish among them are chief (of the particular medical or surgical department), senior, associate, assistant, junior assistant and research assistant.

"Attending" physicians is used by most English hospitals to name those who perform the functions described above. For the same physicians some hospitals use other terms: active staff, clinical staff, medical staff, and full-time medical staff (Queen Mary Veterans).

Our study includes all English-Montreal attending physicians as "attending" whether or not they hold other types of staff affiliation.

Unaffiliated

These are physicians with English preferred language who have no formal affiliation to an English hospital--they do not show up on any of the lists. We might ask whether we are wrong in supposing these are English-Montreal physicians, or whether perhaps they have attending affiliation at a French hospital and thus are members of the French-Montreal medical system.

For the following reasons we assume this is not the case. In 1964, according to Demers,¹ 72 attending-staff

¹Guy Demers, op. cit., p. 81 Tableau 24 and p. 47 Tableau 11.

positions at French hospitals were held by non French-Canadian physicians. However only 24 of these were held by British Isles and Jewish physicians (by ethnic origin). Thus 48 were held by other non-French ethnic physicians among whom the proportion assimilated to French Montreal is much higher. One of the hospitals Demers classified as French--the Bellechasse--we included with the English. Ten of this hospital's physicians in 1967 had British Isles and Jewish, and 7 had other non-French ethnic origin. Thus perhaps only about 55 non-French-Canadian physicians were at French hospitals in 1964, if we exclude the Bellechasse. We suggest that most of these are members of the French-Montreal medical system.

We secured staff lists from four French hospitals presumed most likely to have English physicians on staff.¹ Of English-Montreal "unaffiliated" physicians, nine (4.84%) had attending affiliation at these hospitals. Nineteen English-Montreal attending physicians, one partially affiliated and two consulting physicians also had attending affiliation at these four hospitals.

Finally we looked to see whether a greater proportion of unaffiliated physicians could speak French at all compared to the other English staff categories, especially attending (the Quebec College coded up to three languages in addition to preferred language). We found that 68.98% of attending physicians with English preferred language could speak French, compared to 66.13% of unaffiliated, 66.27% of partially affiliated, and 62.77% of consulting physicians. The rate for all non-attending physicians was 65.02%. Thus, as regards language, the "unaffiliated" are slightly less well equipped than English attending physicians to be integrated into the French hospital system.

We may assume, therefore, that our "unaffiliated" physicians do not consider themselves French-Montreal physicians, except perhaps for a few (around 5%) with attending affiliation at French hospitals.

It is possible that some physicians with French preferred language and no attending affiliation at an English hospital interact mostly in the English-Montreal medical community and think of themselves as English-Montreal physicians. If there are any such they are not included in this study.

¹Les hôpitaux Général Fleury, Jean Talon and Santa Cabrini, and l'Institut de Réhabilitation. The Santa Cabrini is an Italian hospital (see Demers *op. cit.*, p. 133) but its administration functions more in French than in English (information from the hospital).

Partial Affiliation Only

These physicians are usually referred to as "partially affiliated" in the study, although this category includes only those with partial affiliation who have neither consulting nor attending affiliation.

These are physicians with some privileges at a hospital to admit and treat their patients but who are not full members of the medical staff. Although strictly speaking consultants are also not full members of the medical staff they are excluded from the partially affiliated category.

The partially affiliated have restrictions of some kind on their privileges. They may not vote; or hold office usually; or they may hold lower offices on some more minor committees; or they must work under the direct supervision of an attending physician. If involved in the hospital's teaching functions, presumably it would be in a minor capacity.

In Appendix C Tables C:2 and C:3 we divided the partially affiliated physicians into two sub-categories, labelled "out patient" and "courtesy/visiting" staff. Of the 67 partially affiliated physicians, 49 have the former and 20 the latter affiliation (2 have both types).

In studying partial affiliation types it was apparent that certain categories are a preliminary stage to gaining full attending-staff membership. For example, quite a few hospitals require a physician to spend a year in closely supervised practice at the hospital before he may be admitted to the attending staff. These we labelled "out patient" staff because a hospital sometimes requires the provisional physician to serve in the out-patient clinics. Perhaps the term "provisional" staff indicates better the differentiation of this type. This category includes these staff types: out-patient department staff, assistants or associates in outdoor clinics, general practitioner clinic staff (Queen Mary Veterans),¹ associate attending, provisional staff, and, at one hospital,² department of general practice staff.

Other categories of partially affiliated staff are not preliminary to full staff membership, but rather are simply a means of allowing certain physicians to use some of the

¹This hospital also has a staff of physicians employed full-time and of "consultants" who provide their services part-time. Presumably the general practitioners would not move into either of these categories and so are not "provisional."

²St. Mary's. It is not known whether this standing is provisional to membership on the attending staff.

hospital's facilities without seeking to involve them more actively in the hospital's medical affairs. For example, St. Mary's has lists of courtesy staff in medicine, surgery, ob/gyne and paediatrics: physicians who may on occasion use the hospital for their specialized practice. These physicians do not normally go on to attending staff membership at the hospital. They are usually more restricted than out-patient staff in the extent to which they can become involved in the hospital's medical business. The category includes these staff types: courtesy, specialist courtesy, visiting, affiliate, and adjunct (Neuro).

We might note that among attending physicians, 48 (4.76%) also have out-patient affiliation, and 100 (9.92%) have courtesy/visiting affiliation at English hospitals (see Appendix C Tables C:2 and C:3 where these are shown by general and special hospitals).

Consulting Only

We refer to this category in the study as "consultants" or "consulting affiliation," although it includes only those consultants who have neither attending nor partial affiliation. These physicians also have restricted functions at a hospital. Thus their affiliation is also strictly speaking "partial." However, in view of the honorific feature attached to consulting affiliation, and the fact that they represent ex-attending physicians for the most part, we have treated this category separately.

The category includes these staff types: consultants, consulting staff, attending or active consultants, consulting specialists and, at one hospital,¹ honorary consultants. Except for consulting specialists,² all these types appear to be ex-attending physicians, since most hospitals usually appoint their attending physicians on retirement (at age 62 or 65; or later depending on the discretion of the board)³

¹The Royal Victoria. Its "honorary consultants" were included because the hospital has no regular consulting category. Presumably this category corresponds to honorary attending as an affiliation for some of its attending physicians upon retirement.

²And the Queen Mary Veterans hospital "consulting staff" which, unlike most "consultants" consists of physicians who perform many of the functions of "attending" physicians. They are paid sessional fees by the federal government for this work.

³88.32% of consulting physicians are aged 62 or over, compared to 5.65% of attending, 23.66% of unaffiliated, and 1.49% of partially affiliated physicians.

either to the consulting or the honorary attending staff (depending on their length of service and rank at time of retirement). If consultants were previously members of the attending staff, they may retain admitting and treatment privileges. If they were or are attending staff at some other hospital they may not have privileges. In neither case do they take an active part in the medical staff's business.

Consulting affiliation usually entails that the physician agree to provide his services in consultation when requested by an attending physician at the hospital. However, the latter physicians are not obliged to call upon their hospital's consultants for consultation. Consultants may also act in an advisory capacity to the hospital.

Consulting specialists appear to be younger physicians, usually on the medical faculty, who agree to provide consulting services.

Except at the Royal Victoria, our consulting category excludes all physicians who only have "honorary consulting" affiliation, although some of these might appear among the unaffiliated. The honorary consulting are very frequently retired physicians who are only involved in the hospital in an honorific, publicity and prestige capacity.

We might mention finally--as the tables note--that our 1,414 total physicians includes 16 who have both partial affiliation and consulting affiliation but no attending affiliation. They are included in the statistics but are nowhere shown separately.

APPENDIX B

DATA ON ENGLISH-MONTREAL HOSPITALS

Note: A nil entry in these tables is indicated either by "nil" or by "0.00"

APPENDIX B

TABLE B:1.--List of English hospitals, showing hospital-identification number, full name and abbreviated name; and purpose of each of the special hospitals

Note: Hospitals are referred to in the study by their abbreviated names, shown in brackets. Numbers are used to identify hospitals on the maps in Appendix E.

General Hospitals

Voluntary General Hospitals:

1. Royal Victoria Hospital (Royal Victoria)
2. Montreal General Hospital (Montreal General)
3. Jewish General Hospital (Jewish General)
4. St. Mary's Memorial Hospital (St. Mary's)
5. Queen Elizabeth Hospital of Montreal (Queen Elizabeth)
6. Reddy Memorial Hospital (Reddy Memorial)
7. Lakeshore General Hospital (Lakeshore)
8. Lachine General Hospital (Lachine)

Proprietary General Hospitals:

9. Bellechasse Hospital (Bellechasse)
10. Doctors Hospital Inc. (Doctors)
11. Eastern Hospital Inc. (Eastern)
12. Mayfair Hospital (Mayfair)
13. Mount Royal Hospital (Mount Royal)

Federal General Hospital:

14. Queen Mary Veterans Hospital (Queen Mary)

Special Hospitals

Voluntary Acute Hospitals:

15. Montreal Children's Hospital (Children's), paediatric hospital.
16. Montreal Neurological Institute and Hospital (Neuro), neurology and neurosurgery; functions as a separate hospital and as the Department of Neurology and Neurosurgery of the Royal Victoria to which it is joined by an enclosed passageway.
17. Royal Edward Chest Hospital (Royal Edward), general chest conditions (100 beds) and tuberculosis (24 beds).
18. Douglas Hospital (Douglas), mental hospital.

19. Alexandra Hospital (Alexandra), infectious diseases (90 beds), and tuberculosis (52 beds); the tuberculosis unit has been closed since the end of 1966; the future of the hospital is uncertain due to the low incidence of infectious diseases.
20. Catherine Booth Hospital (Catherine Booth), maternity hospital, with some adult medicine and surgery for women.
21. Shriners Hospital for Crippled Children (Shriners), orthopedic hospital for children.

Voluntary Chronic and Convalescent Hospitals:

22. Montreal Protestant Hospital (Montreal Protestant), chronic hospital.
23. Grace Dart Hospital (Grace Dart), chronic hospital.
24. Julius Richardson Convalescent Hospital (Julius Richardson), convalescent hospital.
25. Children's Mountain Cottage Convalescent Home (Children's Cottage), convalescent hospital.
26. Montreal Convalescent Hospital (Montreal Convalescent), convalescent hospital.
27. Maimonides Hospital and Home for the Aged (Maimonides), chronic hospital.
28. Jewish Hospital of Hope (Hospital of Hope), chronic hospital.
29. Jewish Convalescent Hospital (Jewish Convalescent), convalescent hospital.

Federal Chronic and Mental Hospital:

30. Ste. Anne's Hospital (Ste. Anne's), 642 beds for chronic and domiciliary care, and 453 beds for the care of mental patients.
-

Proprietary General Hospital (not included in the study):

31. Kateri Memorial Hospital (45 beds), owned by and operated for the Indian Band of Caughnawaga.

Proprietary Chronic and Convalescent Hospitals (not included in the study):

32. Bayview Hospital Inc. (52 beds)
33. Bussey Chronic and Convalescent Hospital (40 beds)
34. Greenfield Park Private Chronic Hospital (30 beds)
35. Zion Garden Convalescent Home (28 beds)
36. Notre Dame de Grace Private Hospital Reg'd (16 beds)
37. Doctor Dance Memorial Hospital (14 beds)

TABLE B:2.--List of general-hospital categories,^a individual hospitals included, date of establishment, and nature of sponsorship

Category, Hospital, and Date of Establishment ^b	Nature of Sponsorship
<u>Category G1 - Major McGill^c Teaching-Hospitals:</u>	
Royal Victoria - 1894 Montreal General - 1821	Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community. ^d
<u>Category G2 - Jewish Hospital; Associated with McGill:^e</u>	
Jewish General - 1934	Voluntary non-profit corporation, Board of management drawn from Jewish community; member of Allied Jewish Community Services.
<u>Category G3 - Catholic Hospital; Associated with McGill:</u>	
St. Mary's - 1924	Voluntary non-profit corporation, board of management drawn from English-speaking Catholic community.
<u>Category G4 - Other Voluntary Hospitals Associated with McGill:</u>	
Queen Elizabeth - 1894 Reddy Memorial - 1871	Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community.
<u>Category G5 - Voluntary Hospitals; not Associated with McGill:</u>	
Lakeshore - 1960 Lachine - 1909	Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community.
<u>Category G6 - Proprietary Hospitals; not Associated with McGill:</u>	
Bellechasse - 1962	Private ownership; one of six shareholders a physician.
Doctors - 1947) Eastern - 1960) Mayfair - 1958) Mount Royal - 1936)	Private ownership; physician owned.
<u>Category G7 - Public Hospital; Associated with McGill:</u>	
Queen Mary - 1945	Federal-government owned: Department of Veterans Affairs.

Footnotes: See following page.

TABLE B:2.--Continued

^aFor simplicity the categories are sometimes referred to in the text by these short-hand descriptions:

G1: major teaching	G5: non-teaching
G2: Jewish partial-teaching	G6: proprietary
G3: Catholic partial-teaching	G7: public
G4: Protestant partial-teaching	

^bDate of establishment refers to when the hospital corporation was first set up. Thus the Lakeshore General was established in 1960 but did not take patients until 1965. The Montreal General, on the other hand, was a functioning hospital in the 1820's but opened at its present location only in the 1950's.

^c"McGill" refers to McGill University's Faculty of Medicine. The Dean of the Faculty is an ex officio member of the boards of management of these hospitals.

^d"Drawn from English/Scottish Protestant community" means the majority of board members are of these ethnic origins, usually associated with Protestantism. It is generally recognized in the City that these hospitals were built and are controlled by British-origin Protestants.

^eAssociated with McGill's Faculty of Medicine only for the graduate training of physicians.

Sources: Establishment date: Canadian Hospital Directory 1966 (Toronto: Canadian Hospital Association, 1966).
Teaching status: McGill University, Faculty of Medicine 1966-1967, Montreal; and interviews 7, 20.
Sponsorship: Canadian Hospital Directory; interviews 18, 22, 23, 24. Boards of management: annual reports of the hospitals.

TABLE B:3.--General hospitals: elements of formal approval,
part one

Category and Hospital	Accredited Hospital ^a	Teaching Hospital ^b	Approved Nursing School ^c	Psychiatric Unit
<u>Category G1:</u>				
Royal Victoria	yes	yes	yes	yes
Montreal General	yes	yes	yes	yes
<u>Category G2:</u>				
Jewish General	yes	(no) ^d	yes	yes
<u>Category G3:</u>				
St. Mary's	yes	no	yes	no
<u>Category G4:</u>				
Queen Elizabeth	yes	no	yes	no
Reddy Memorial	yes	no	no	no
<u>Category G5:</u>				
Lakeshore	no	no	no	no
Lachine	yes	no	no	no
<u>Category G6:</u>				
Bellechasse	yes)))
Doctors	yes)))
Eastern	no	)no	)no	)no
Mayfair	no)))
Mount Royal	no)))
<u>Category G7:</u>				
Queen Mary	yes	(yes) ^e	no	yes

Footnotes: see following page.

TABLE B:3.--Continued

^aAccredited by the Canadian Council on Hospital Accreditation.

^bEngages in undergraduate teaching of medical students. All the English hospitals where undergraduate teaching is done are affiliated with McGill University's Faculty of Medicine. "Teaching hospital" is explained in Appendix A.

^cApproval by the Association of Nurses of the Province of Quebec.

^dThough not considered a McGill "teaching hospital," a small amount of undergraduate teaching in psychiatry is carried on at this hospital. Interviews 5, 7.

^eA relatively limited amount of undergraduate teaching is done at this hospital in medicine, psychiatry and surgery.

Sources: Accreditation: Canadian Hospital Directory 1966, op. cit. (previously cited in the tables' notes); Listing of Hospitals, Related Institutions and Facilities, Department of National Health and Welfare, Ottawa, March 1967. Teaching hospitals: McGill University, Faculty of Medicine 1966-1967; interviews 5, 7, 20. Approved nursing school: Canadian Association of Nurses, and Canadian Hospital Directory 1966. Psychiatric unit: DBS, List of Canadian Hospitals and Related Institutions and Facilities 1966, Ottawa: 1967.

TABLE B:4.--General hospitals: elements of formal approval,
part two

Category and Hospital	Associated with McGill ^a	Approved for Internship		Approved for Residency	
		Quebec College ^b	CMA ^c	Quebec College	Royal College ^d
<u>Category G1:</u>					
Royal Victoria	yes	yes	yes	yes	yes
Montreal General	yes	yes	yes	yes	yes
<u>Category G2:</u>					
Jewish General	yes	yes	yes	yes	yes
<u>Category G3:</u>					
St. Mary's	yes	yes	yes	yes	yes
<u>Category G4:</u>					
Queen Elizabeth	yes	yes	yes	yes	yes
Reddy Memorial	yes	yes	yes	yes	yes
<u>Category G5:</u>					
Lakeshore	no	yes	no	yes	no
Lachine	no	no	no	no	no
<u>Category G6:</u>					
Bellechasse	no	no	no	yes	no
Doctors	no	no	no	no	no
Eastern					
Mayfair					
Mount Royal					
<u>Category G7:</u>					
Queen Mary	yes	no	no	yes	yes

Footnotes: See following page.

TABLE B:4.--Continued

^aAssociated with McGill University's Faculty of Medicine for the graduate training of physicians.

^bThe College of Physicians and Surgeons of the Province of Quebec.

^cThe Canadian Medical Association.

^dThe Royal College of Physicians and Surgeons of Canada.

Sources: Association with McGill: interviews 5, 7, and 20 and non-published documents provided by these physicians. Approval for internship: Quebec College, Quebec Hospitals Approved for Internship and Residency (Montreal: January, 1967); "General Hospitals in Canada Approved by the Canadian Medical Association for Junior Intern Training," CMAJ, XCVI (September 10, 1966), pp. 589-90. Approval for residency: Quebec College, op. cit.; "Canadian Hospitals Approved for Advanced Graduate Study by the Royal College of Physicians and Surgeons of Canada," CMAJ, XCVI (April 1, 1967), pp. 993-1002.

TABLE B:5.--General hospitals approved for residency training: number of residents on staff, and number of specialties for which training is approved

Category and Hospital	Number of Residents and Fellows ^a	Number of Specialties Approved ^b			
		Total	Two-year Training ^c	Three-year and over Training ^d	Unlimited Number of Residents ^e
<u>Category G1:</u>					
Royal Victoria	277	24 (18)	11 (2)	12 (16)	23 (16)
Montreal General	184	24 (20)	11 (1)	11 (16)	20 (18)
<u>Category G2:</u>					
Jewish General	57	16 (12)	6 (2)	2 (4)	7 (3)
<u>Category G3:</u>					
St. Mary's	26	10 (6)	5 (1)	nil (nil)	nil (3)
<u>Category G4:</u>					
Queen Elizabeth Reddy Memorial	24 5	7 (7) 5 (6)	nil (nil) nil (nil)	nil (nil) nil (nil)	1 (1) nil (3)
<u>Category G5:</u>					
Lakeshore	16	7 (approved only by Quebec College)	nil	nil	nil
<u>Category G6:</u>					
Bellechasse	8	2 (approved only by Quebec College)	nil	nil	nil
<u>Category G7:</u>					
Queen Mary	66	13 (16)	nil (nil)	nil (nil)	3 (11)

Footnotes: see following page.

TABLE B:5.--Continued

^aResidents and fellows on the hospitals' lists for the year 1966-1967. It is not known whether there is any duplication.

^bIn these columns, numbers in brackets refer to approval by the Royal College, numbers without brackets refer to approval by the Quebec College.

^cSpecialties for which the hospital is approved to give two-year training.

^dSpecialties for which the hospital is approved to give three-year training or more.

^eSpecialties for which the approving agency does not limit the number of residents.

Note:

Though not approved for training, the Lachine General has five residents on staff, all from other countries. Though we are not concerned here with interns, we might note that two proprietary hospitals have, between them, four "interns" on staff, all from foreign medical schools.

Sources: Number of residents and fellows: lists provided by Quebec College. Number of specialties approved: Quebec Hospitals Approved for Internship and Residency, op. cit.; "Canadian Hospitals Approved for Advanced Graduate Study by the Royal College of Physicians and Surgeons of Canada."

TABLE B:6.--General hospitals: number of beds, total expenditures per bed, and endowment funds in total and per bed, 1965

Category and Hospital	Number of Beds ^a	Total Expenditures per Bed	Endowment Funds ^b	
			Total	Per Bed
		\$	\$'000	\$
<u>Category G1:</u>				
Royal Victoria	1,018	18,619	8,349	8,201
Montreal General	743 ^c	18,191	5,837	7,855
<u>Category G2:</u>				
Jewish General	397	18,391	1,129 ^d	2,850
<u>Category G3:</u>				
St. Mary's	350	15,341	60	172
<u>Category G4:</u>				
Queen Elizabeth	264	13,354	206	782
Reddy Memorial ^e	134	13,331	355	2,650
<u>Category G5:</u>				
Lakeshore	275	10,100 ^f	nil	nil
Lachine	138	9,774	269	1,952
<u>Category G6:</u>				
Bellechasse	176	12,216	nil	nil
Doctors	65	9,068	nil	nil
Eastern	41	7,317	nil	nil
Mayfair	36	6,944	nil	nil
Mount Royal	10	3,000	nil	nil
<u>Category G7:</u>				
Queen Mary	700	8,023	nil	nil

Footnotes: see following page.

TABLE B:6.--Continued

^aNumber of beds set up, rather than rated bed capacity.

^b"Endowment funds" include endowment and special funds. Endowment funds "are generally those permanent funds which are to be kept intact as to principal and of which only the income may be used. There are usually two types of endowment funds: (a) endowments unrestricted as to income; (b) endowments restricted as to income. . . . Special-purpose funds, unlike the assets of endowment funds, are to be expended in their entirety for the purpose for which they were created. They may be obtained in the form of gifts or bequests, or as income from assets of an endowment fund restricted as to income." Malcolm T. MacEachern, Hospital Organization and Management (Chicago: Physicians' Record Company, 1957), pp. 879-80. Hospitals account for their assets and liabilities under three main funds: plant, revenue, and endowment. Canada, DBS, Hospital Statistics, Vol. IV, Balance Sheets, 1965 (Ottawa: Queen's Printer, 1967).

^cThis hospital had increased to 850 beds in 1967.

^dThe Jewish General accounts for "Life Governor's Funds" separately from endowment funds. A "Life Governor" is someone who has made a gift of \$1,000 or more to the hospital. If these were included with "endowment funds" the total and per-bed endowment funds would be \$1,656,000 and \$4,160.

^eIn 1967 this hospital was building an addition that would bring it up to 225 beds. Interview 8.

^fThis is a new hospital: the "construction and running in" period was 3.5 months and the "operating" period 8.5 months in 1965. The relatively low unit expenses could be due, at least partly, to unusually low total expenses during the first year of a hospital's operation.

Sources: Number of beds: Canadian Hospital Directory 1966. Expenditures and endowments: annual reports of the hospitals for 1965, and Canadian Hospital Directory 1966.

TABLE B:7.--Percentage distribution of physicians by general hospital and by ethnic origin

Category and Hospital	English and Scottish ^a	Jewish ^b	Irish ^c	Other non-French ^d	French	Total	
						Per Cent	N
<u>Category G1:</u>	%	%	%	%	%	%	
Royal Victoria	59.18	9.80(11.43)	4.90	17.55(3.26)	8.57	100.00	245
Montreal General	68.39	8.39(9.68)	7.74	11.61(0.00)	3.87	100.00	155
<u>Category G2:</u>							
Jewish General	27.32	60.31(65.46)	0.00	11.34(1.03)	1.03	100.00	194
<u>Category G3:</u>							
St. Mary's	35.37	2.44(2.44)	20.73	28.05(0.00)	13.41	100.00	82
<u>Category G4:</u>							
Queen Elizabeth	62.50	5.56(5.56)	5.56	22.22(2.78)	4.17	100.00	72
Reddy Memorial	38.27	28.40(28.40)	0.00	32.10(1.24)	1.23	100.00	81
<u>Category G5:</u>							
Lakeshore	48.84	3.49(5.82)	3.49	25.58(4.65)	18.60	100.00	86
Lachine	52.38	7.14(9.52)	2.38	33.33(0.00)	4.76	100.00	42
<u>Category G6:</u>							
Bellechasse	6.78	10.17(18.64)	0.00	11.86(0.00)	71.19	100.00	59
Doctors	3.23	25.81(25.81)	0.00	58.06(6.45)	12.90	100.00	31
Eastern)							(9
Mayfair) ^e	7.69	53.85(53.85)	0.00	30.77(7.69)	7.69	100.00	(1 ^f
Mount Royal)							(3
<u>Category G7:</u>							
Queen Mary	25.00	12.50(12.50)	6.25	12.50(0.00)	43.75	100.00	16
Total	43.79	19.26(21.50)	4.70	19.93(2.01)	12.32	100.00	893 ^g

Footnotes: see following page.

TABLE B:7.--Continued

^aIncludes Welsh.

^bFigures in brackets are the proportion of Jewish physicians if we include physicians who were identified as Jewish by religion but not by ethnic origin. This may be taken as a "minimum" proportion of Jewish physicians; "minimum" because data on religious affiliation were available for only 141 of 1,414 English-Montreal physicians. The number of Jewish physicians in Montreal is discussed more fully in Appendix A, Physicians section.

^cNorthern Ireland and Eire.

^dFigures in brackets shown show the proportion of the appropriate "total" physicians, included with "other non-French," who have non-European ethnic origins.

^eSo as to conceal data on individual physicians and make percentages meaningful, these hospitals are treated together.

^fAn "open hospital" this institution has a medical director but no formal attending staff. "Open" and "closed" hospitals are discussed in Appendix A, Hospitals section.

^gThis figure is not the sum of the N column, because it removes duplication among categories. The sum of the N column would yield total positions; 893 is total physicians. Duplication among hospitals of the same category remains, since each N is the total number of attending positions--held by physicians of metropolitan Montreal, of course. Thus the 400 attending positions at G1, for example, are held by 379 physicians. The data in Tables B:7 to B:10 and in Tables B:16 to B:19 may be compared with data on all physicians and on all attending physicians in Tables B:20 to B:23.

TABLE B:8.--Percentage distribution of physicians by general hospital and by specialization characteristics^a

Category and Hospital	Specialization		Royal College		N ^d (100%)	One Agency Only ^e			2 or More Certificates ^g	N ^h (100%)
	No Certificate	1 or More Certificates ^b	Fellowship	Total ^c		Quebec Coll.	Royal Coll.	N ^f (100%)		
	%	%	%	%		%	%	%		
<u>Category G1:</u>										
Royal Vic.	4.49	95.51	53.06	83.67	245	12.39	3.42	234	29.64	226
Montreal Gen.	2.58	97.42	65.81	92.91	155	4.64	1.99	151	31.08	148
<u>Category G2:</u>										
Jewish Gen.	12.89	87.11	28.87	72.17	194	17.16	1.78	169	21.08	166
<u>Category G3:</u>										
St. Mary's	2.44	97.56 ⁱ	39.02	79.26	82	18.75	0.00	80	20.00	80
<u>Category G4:</u>										
Queen Eliz.	11.11	88.89	30.56	70.84	72	20.31	4.69	64	22.95	61
Reddy Mem.	12.35	87.65	37.04	75.31	81	14.08	1.41	71	22.86	70
<u>Category G5:</u>										
Lakeshore	18.60	81.40	23.26	65.12	86	20.00	7.14	70	16.92	65
Lachine	19.05	80.95	14.29	64.29	42	20.59	5.88	34	15.63	32
<u>Category G6:</u>										
Bellechasse	55.93	44.07	20.34	35.59	59	19.23	3.85	26	24.00	25
Doctors	64.52	35.48	3.23	29.04	31	18.18	27.27	11	25.00	8
Eastern)					(9			((
Mayfair) ^j	61.54	38.46	7.69	30.77	(1	20.00	20.00	(5	0.00	(4
Mount Royal)					(3			((
<u>Category G7:</u>										
Queen Mary	31.25	68.75	12.50	62.50	16	9.09	9.09	11	20.00	10
Total	15.90	84.10	37.40	70.88	893^k	15.71	3.60	751^k	22.92	724^k

Footnotes: see following page.

TABLE B:8.--Continued

^aPercentages read horizontally, although only the first two columns add up to 100%. Note the changing N in each row.

^bPhysicians with a Quebec College or Royal College specialty certificate, or both. This may be taken as the proportion of specialists. The Quebec College does not recognize specialty certification by foreign agencies, including the American specialty boards (information from Royal College). Column 1 may be taken as the proportion of general practitioners. The terms general practitioner and specialist are discussed in Appendix A, Physicians section.

^cPhysicians with a Royal College fellowship or Royal College specialty certificate.

^dAll attending physicians.

^ePhysicians with certification by one Canadian agency only.

^fAll physicians with certification of the Quebec College, the Royal College, or both. These are the N's of column 2.

^gPhysicians with two or more Quebec College specialty certificates, as a proportion of the next column.

^hAll physicians with Quebec College specialty certification.

ⁱSeven physicians in the department of general practice at this hospital were excluded from the attending-physician category and included with physicians having "partial affiliation" because the medical-staff by-laws exclude them from full attending-staff activity, such as voting at staff meetings and holding office. If they were included with attending physicians, the proportion of physicians with specialty certification would be 89.89%.

^jSee Table B:7 note "e."

^kSee Table B:7 note "g."

TABLE B:9.--Physicians at general hospitals, showing proportions who are consultants, teachers, or researchers^a

Category and Hospital	Consultants ^b		Teachers		Researchers		N (100%)	
	Per Cent	N (100%)	As Main Activity ^c	As Main, 2nd or 3rd Activity ^d	As Main Activity ^e	As Main, 2nd or 3rd Activity ^f		
	%		%	%	%	%		
<u>Category G1:</u>								
Royal Vic.	} 36.15	379	7.76	78.78	7.76	35.51	245	
Mtl. General			3.23	78.42	2.58	23.87	155	
<u>Category G2:</u>								
Jewish Gen.	17.53	194	2.06	26.80	2.06	18.55	194	
<u>Category G3:</u>								
St. Mary's	24.39	82	1.22	39.03	0.00	13.42	82	
<u>Category G4:</u>								
Queen Eliz.	} 17.57	148	1.39	33.34	0.00	9.72	72	
Reddy Mem.			0.00	28.40	0.00	18.52	81	
<u>Category G5:</u>								
Lakeshore	} 8.57	105	0.00	13.96	2.33	4.65	86	
Lachine			0.00	9.52	0.00	4.76	42	
<u>Category G6:</u>								
Bellechasse	} 3.96	101	0.00	8.47	1.69	6.77	59	
Doctors			0.00	0.00	3.23	9.69	31	
Eastern			} 0.00	0.00	0.00	0.00	0.00	9
Mayfair								1
Mount Royal	3							
<u>Category G7:</u>								
Queen Mary	18.75	16	0.00	18.75	0.00	25.00	16	
Total	22.06	893^h	3.02	43.11	3.14	20.05	893^h	

Footnotes: see following page.

TABLE B:9.--Continued

^aPercentages read horizontally, although they do not add up to 100%. Note the changing N in each row.

^bPhysicians with consulting-staff status at another English-Montreal hospital. Some physicians in a hospital category may be consultants at another hospital of the same category. These data were not calculated for individual hospitals on computer runs.

^cPhysicians whose main professional activity is basic-sciences or clinical teaching.

^dPhysicians who are engaged in medical education as defined above, as a main, second or third professional activity.

^ePhysicians whose main professional activity is medical research either at a hospital or within some other milieu.

^fPhysicians who are engaged in research as defined above, as a main, second or the third professional activity.

^gSee Table B:7 note "e."

^hSee Table B:7 note "g."

TABLE B:10.--Percentage distribution of physicians by general hospital and by office location^a

Category and Hospital	West Island				West Center	East Center	North/East Island	Ile Jésus	Envi-rons	Metropolitan Montreal		
	Far West	French West	West City	Total						Per Cent	N	
	%	%	%	%	%	%	%	%	%	%		
<u>Category G1:</u>												
Royal Vic.	2.86	0.00	22.04	24.90	68.16	1.63	5.31	0.00	0.00	100.00	245	
Mtl. General	1.29	0.00	14.84	16.13	79.35	0.00	3.23	0.00	1.29	100.00	155	
<u>Category G2:</u>												
Jewish Gen.	0.00	0.00	76.80	76.80	16.49	3.61	2.58	0.52	0.00	100.00	194	
<u>Category G3:</u>												
St. Mary's	2.44	0.00	64.63	67.07	23.17	2.44	6.10	0.00	1.22	100.00	82	
<u>Category G4:</u>												
Queen Eliz.	1.39	0.00	76.39	77.78	15.28	2.78	4.17	0.00	0.00	100.00	72	
Reddy Mem.	0.00	0.00	49.38	49.38	41.98	6.17	2.47	0.00	0.00	100.00	81	
<u>Category G5:</u>												
Lakeshore	66.28	3.49	10.46	80.23	13.95	0.00	3.49	0.00	2.33	100.00	86	
Lachine	52.38	19.05	16.67	88.10	9.52	0.00	0.00	2.38	0.00	100.00	42	
<u>Category G6:</u>												
Bellechasse	1.69	0.00	15.26	16.95	3.39	5.08	74.58	0.00	0.00	100.00	59	
Doctors	3.23	0.00	48.38	51.61	12.90	25.81	9.68	0.00	0.00	100.00	31	
Eastern	}b	0.00	7.69	7.69	7.69	23.08	61.54	0.00	0.00	100.00	(9	
Mayfair												(1
Mount Royal													( 3
<u>Category G7:</u>												
Queen Mary	12.50	0.00	62.50	75.00	6.25	6.25	6.25	6.25	0.00	100.00	16	
Total	8.06	1.01	39.08	48.15	37.63	3.36	9.97	0.34	0.56	100.00	893 ^c	

Footnotes: see following page.

TABLE B:10.--Continued

^aThe location of statistical areas in metropolitan Montreal is illustrated in Appendix E, maps 2 and 5. The boundaries of metropolitan Montreal are shown in Appendix E, map 1. The location of English-Montreal hospitals is illustrated in Appendix E, maps 3, 4, and 5. Finally, the location of the population of Montreal, by ethnic origin and by official-language spoken is presented in Appendix E, Tables E:1 to E:6. Table E:7 shows population density in concentric rings from the city-center, that can suggest relative density in the statistical areas used in the study.

^bSee Table B:7 note "e."

^cSee Table B:7 note "g."

TABLE B:11.--List of special-hospital categories,^a individual hospitals included, date of establishment, and nature of sponsorship

Category, Hospital, and Date of Establishment ^b	Nature of Sponsorship
ACUTE HOSPITALS	
<u>Category S1 - Major McGill^c</u> Children's - 1904) Neuro ^e - 1934)	<u>Teaching-Hospitals:</u> Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community. ^d
<u>Category S2 - Other McGill^c</u> Royal Edward - 1942) Douglas ^g - 1890) Alexandra - 1906)	<u>Teaching-Hospitals:^{c,f}</u> Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community.
<u>Category S3 - Non-teaching Hospitals:</u> Catherine Booth - 1904 Shriners - 1925	Non-profit hospital owned and operated by the Salvation Army. Non-profit hospital owned and operated by the philanthropic Shriners Movement.
CHRONIC AND CON-VALESCENT HOSPITALS	
<u>Category S4 - Christian</u> Montreal Protestant-1863) Grace Dart - 1907) Julius Richardson - 1952) Children's Cottage - 1962) Montreal Convaless. - 1914	<u>Chronic and Convalescent Hospitals:</u> Voluntary non-profit corporation, board of management drawn from English/Scottish Protestant community. Voluntary non-profit corporation, board of management drawn from English-speaking Catholic community.
<u>Category S5 - Jewish</u> Maimonides - 1928) Hospital of Hope - 1942) Jewish Convaless. - 1966)	<u>Chronic and Convalescent Hospitals:</u> Voluntary non-profit corporation, board of management drawn from Jewish community; member of Allied Jewish Community Services.
<u>Category S6 - Public Hospital, Chronic and Mental:</u> Ste. Anne's - 1917	Federal-government owned: Department of Veterans Affairs

Footnotes: see following page.

TABLE B:11.--Continued

^aFor simplicity the categories are sometimes referred to in the text by these short-hand descriptions:

S1: major-teaching	S4: Christian chronic
S2: partial-teaching	S5: Jewish chronic
S3: non-teaching	S6: public chronic

^{b,c, and d}These notes correspond to "b," "c," and "d" in Table B:2.

^eThis hospital is owned by McGill University.

^fRelatively limited in the amount of undergraduate teaching carried on.

^gAlthough the Dean of the Faculty of Medicine is not on the board of this hospital, the chairmen of the Faculty's Departments of Psychiatry, and Neurology and Neurosurgery are. See annual report of the hospital for 1965 and McGill University, Faculty of Medicine 1966-1967, Montreal.

Sources: Same as Table B:2.

TABLE B:12.--Special hospitals: elements of formal approval, part one

Category and Hospital	Accredited Hospital ^a	Teaching Hospital ^b	Nursing School and Psychiatric Unit
ACUTE HOSPITALS			
<u>Category S1:</u>			
Children's Neuro	yes yes	yes yes	psychiatric unit no
<u>Category S2:</u>			
Royal Edward Douglas Alexandra	yes no yes	yes yes ^d yes	} no ^c
<u>Category S3:</u>			
Catherine Booth Shriners	yes yes	no (no) ^e	} no
CHRONIC AND CON-VALESCENT HOSPITALS			
<u>Category S4:</u>			
Montreal Protestant Grace Dart Julius Richardson Children's Cottage Montreal Convales.	no yes no no no	} } no } }	} } no } }
<u>Category S5:</u>			
Maimonides Hospital of Hope Jewish Convales.	no yes no	} } no }	} } no }
<u>Category S6:</u>			
Ste. Anne's	yes	no	psychiatric unit ^f

Footnotes: see following page.

TABLE B:12.--Continued

a and b These notes correspond to "a" and "b" in Table B:3.

^cThe Douglas is a mental hospital and therefore does not have a separate psychiatric unit.

^dBeginning Autumn 1967 the Alexandra no longer engages in undergraduate teaching. It did, however, in the Spring of 1967 to which period the data on physicians relates. Information from hospital official.

^eAlthough not considered one of its teaching hospitals by McGill, a small amount of undergraduate training in paediatric surgery is given to fourth-year medical students at the Shriners. McGill University, Faculty of Medicine 1966-1967, Montreal.

^fThis hospital has a physically-separate 453-bed mental-patient unit.

Sources: Same as Table B:3.

TABLE B:13.--Special hospitals: elements of formal approval, part two

Category and Hospital	Associ- ated with McGill ^a	Approved for part of Internship ^e		Approved for Residency	
		Quebec Coll. ^b	CMA ^c	Quebec Coll.	Royal Coll. ^d
ACUTE HOSPITALS					
<u>Category S1:</u>					
Children's Neuro	yes yes	yes ^f no	yes no	yes yes	yes yes
<u>Category S2:</u>					
Royal Edward Douglas Alexandra	yes yes no	yes ^g no no	no no no	yes yes no	yes yes no
<u>Category S3:</u>					
Catherine Booth Shriners	no } no } ^k	yes ^h no	yes no	yes yes	yes yes
CHRONIC AND CON- VALESCENT HOSPITALS					
<u>Category S4:</u>					
Montreal Protestant) Grace Dart) Julius Richardson) Children's Cottage) Montreal Convales.)	no	no	no	no	no
<u>Category S5:</u>					
Maimonides) Hospital of Hope) Jewish Convales.)	no	no	no	no	no
<u>Category S6:</u>					
Ste. Anne's	no ⁱ	no	no	yes ^j	yes ^j

Footnotes: see following page.

TABLE B:13.--Continued

a, b, c, and d These notes correspond to "a to d" in Table B:4.

^e"Part of Internship" only because a special hospital does not have all the departments necessary for full training during the compulsory one-year rotating internship.

^fTakes interns on rotation from the Royal Victoria, Montreal General, Queen Elizabeth and Reddy Memorial hospitals.

^gTakes interns on rotation from the Royal Victoria and Montreal General hospitals.

^hTakes interns on rotation from the Montreal General hospital.

ⁱAssociated indirectly with McGill through the Queen Mary Veterans Hospital whose residents rotate through Ste. Anne's hospital, for four months. Interview 17.

^jApproved for residency training but only in psychiatry since the hospital comprises a 453-bed mental-hospital unit.

^kAlthough not considered associated hospitals by McGill, these two have partial residencies (of six months at one, and one year at the other) that are "integrated in a university program of graduate training," and are controlled by one of the directly associated hospitals. See "Canadian Hospitals Approved for Advanced Graduate Training by the Royal College . . .," pp. 888, 890 and 1001.

Sources: Same as Table B:4.

TABLE B:14.--Special hospitals approved for residency training: number of residents on staff, and number of specialties for which training is approved

Category and Hospital	Number of Residents and Fellows ^a	Number of Specialties Approved ^b			
		Total	Two-year Training ^c	Three-year and over Training ^d	Unlimited No. of Residents ^e
<u>Category S1:</u>					
Children's	130	20 (16)	5 (2)	1 (1)	13 (14)
Neuro	79	5 (4)	nil (nil)	2 (2)	5 (4)
<u>Category S2:</u>					
Royal Edward	10 ^f	3 (2)	1 (nil)	nil (nil)	1 (2)
Douglas	35	1 (1)	nil (nil)	nil (nil)	1 (1)
<u>Category S3:</u>					
Catherine Booth	nil ^g	1 (1)	nil (nil)	nil (nil)	1 (nil)
Shriners	3	1 (1)	nil (nil)	nil (nil)	nil (nil)
<u>Category S6:</u>					
Ste. Anne's	nil ^h	1 (2)	nil (nil)	nil (nil)	nil (nil)

Footnotes: see following page.

TABLE B:14.--Continued

a, b, c, d, and e These notes correspond to "a to e" in Table B:5.

^f Full-time residents. Another 20 are taken on rotation.

^g No full-time residents, although some are taken on rotation.

^h No full-time residents, although six at-a-time are taken on four-months rotation from the Queen Mary Veterans Hospital.

Note:

Though not approved for training, the following special hospitals have residents (their number in brackets) on staff. Alexandra (1); Grace Dart (2); Montreal Convalescent (1); Maimonides (3); Hospital of Hope (3); Jewish Convalescent (2). The "residents in chronic hospitals are frequently foreign graduate physicians who could not get a licence to practice medicine because Canadian citizenship was necessary in Quebec. The hospitals frequently supplement the "resident" salary that the government pays these persons. Thus physicians' careers are affected by formal rulings of professional agencies as well as by informal factors such as acceptance by colleagues. Like all residents, these physicians provide a large part of the hospital's medical care. Interviews 4, 6, 9, 13, 17.

Sources: Same as Table B:5.

TABLE B:15.--Special hospitals: number of beds, total expenditures per bed, and endowment funds in total and per bed, 1965

Category and Hospital	Number of Beds ^a	Total Expenditures per Bed	Endowment Funds ^b	
			Total	Per Bed
		\$	\$'000	\$
ACUTE HOSPITALS				
<u>Category S1:</u>				
Children's	367	22,489	5,683	15,484
Neuro	135	18,700	4,200 ^c	31,000
<u>Category S2:</u>				
Royal Edward	124	16,776	491	3,963
Douglas ^d	1,635	3,140	865	530
Alexandra ^e	142	4,875	795	5,600
<u>Category S3:</u>				
Catherine Booth	78	12,450	nil ^f	nil
Shriners	60	7,248	3,000 ^f	50,000
CHRONIC AND CON-VALESCENT HOSPITALS				
<u>Category S4:</u>				
Montreal Protestant	146	3,487	nil	nil
Grace Dart	128	6,414	1,485	11,604
Julius Richardson	90	4,064	38	420
Children's Cottage	25	5,061	nil	nil
Montreal Convales.	213	4,945	1,387	6,513
<u>Category S5:</u>				
Maimonides	210 ^g	4,815	522	2,485
Hospital of Hope	137	6,812	467	3,408
Jewish Convales.	120	6,250 ^h	nil	nil
<u>Category S6:</u>				
Ste. Anne's	1,095	5,257	nil	nil

Footnotes: see following page.

TABLE B:15.--Continued

a and b These notes correspond to "a" and "b" in Table B:6.

c Estimated on the basis of known earnings from endowment funds (taken as 5% of principal). See annual report of the hospital, 1965-1966.

d As noted in Appendix A, Hospitals section, compared to the acute special hospitals with which it is here classified, the Douglas has a much greater average length of stay of its patients. Mental conditions are generally classified as "chronic" conditions and much less active medical treatment goes on at present in the large mental hospitals than in the acute special hospitals. This partly explains the low unit expenditures. See U.S.A., Department of Health, Education, and Welfare, Public Health Service, United States National Health Survey, 1958-1959.

e Because of the declining incidence of communicable diseases and tuberculosis, the hospital had a low occupancy rate (53%). This partly accounts for the low expenditures.

f Estimated from published figures on donations to Shriners-movement hospitals. See Montreal Star, October 30, 1967, p. 4.

g Rated bed-capacity. DBS, List of Canadian Hospitals . . . 1966, p. 19.

h "Budget" in 1966. The hospital had not opened in 1965. Canadian Hospital Directory 1967 (Toronto: Canadian Hospital Association, 1967).

Sources: Same as Table B:6.

TABLE B:16.--Percentage distribution of physicians by special hospital and by ethnic origin

Category and Hospital	English & Scottish ^a	Jewish ^b	Irish ^c	Other non-French ^d	French	Total	
						Per Cent	N
ACUTE HOSPITALS	%	%	%	%	%	%	
<u>Category S1</u>							
Children's	51.61	18.06 (22.58)	2.58	18.06 (1.93)	9.68	100.00	155
Neuro	47.37	10.53 (10.53)	5.26	21.05 (0.00)	15.79	100.00	19
<u>Category S2:</u>							
Royal Edward	40.00	16.00 (28.00)	4.00	28.00 (0.00)	12.00	100.00	25
Douglas } Alexandra)e	44.44	7.41 (7.41)	7.41	29.63 (0.46)	11.11	100.00	(24 (3
<u>Category S3:</u>							
Catherine B.	60.87	8.70 (8.70)	8.70	17.39 (0.00)	4.35	100.00	46
Shriners	80.00	0.00 (0.00)	10.00	10.00 (0.00)	0.00	100.00	10
CHRONIC/CON-VALESCENT HOS.							
<u>Category S4:</u>							
Grace Dart	80.00	10.00 (10.00)	10.00	0.00 (0.00)	0.00	100.00	10
Mtl. Protest.) Julius Rich. } Chldn's Cott. }e Mtl. Convales.)	40.00	20.00 (20.00)	20.00 ^f	10.00 (0.00)	10.00	100.00	(4 (4 (1 (1
<u>Category S5:</u>							
Maimonides	16.67	70.00 (73.33)	0.00	6.67 (0.00)	6.67	100.00	30
Hos. of Hope	30.00	60.00 (70.00)	0.00	10.00 (0.00)	0.00	100.00	10
Jewish Conval.	20.00	66.67 (66.67)	0.00	13.33 (0.00)	0.00	100.00	15
<u>Category S6:</u>							
Ste. Anne's	42.86	0.00 (0.00)	7.14	35.71 (0.00)	14.29	100.00	14
Total	46.59	21.96 (25.22)	4.45	18.10 (1.19)	8.90	100.00	337 ⁸

Footnotes: see following page.

TABLE B:16.--Continued

^{a to e}These notes correspond to notes "a to e" in Table B:7.

^fBoth physicians are attending staff at the Catholic Montreal Convalescent Hospital.

^gSee Table B:7 note "g."

TABLE B:17.--Percentage distribution of physicians by special hospital and by specialization characteristics^a

Category and Hospital	Specialization		Royal College		N ^d (100%)	One Agency Only ^e			2 or More Certificates ^g %	N ^h (100%)
	No Certificate	1 or More Certificates ^b	Fellowship	Total ^c		Quebec	Canada	N ^f (100%)		
	%	%	%	%		%	%			
ACUTE HOSPITALS										
<u>Category S1:</u>										
Children's	1.29	98.71	36.77	84.51	155	14.38	0.65	153	8.55	152
Neuro	26.32	73.68 ⁱ	42.11	73.68	19	0.00	0.00	14	7.14	14
<u>Category S2:</u>										
Royal Edward	12.00	88.00	36.00	52.00	25	40.91	0.00	22	40.91 ^k	22
Douglas } Alexandra } ^j	25.93	74.07	11.11	51.85	(24 { 3	30.00	10.00	20	5.56	18
<u>Category S3:</u>										
Catherine B.	4.35	95.65	50.00	89.13	46	6.82	0.00	44	63.64 ^k	44
Shriners	0.00	100.00	80.00	100.00	10	0.00	10.00	10	11.11	9
CHRONIC/CONVALESCENT HOS.										
<u>Category S4:</u>										
Grace Dart	10.00	90.00	60.00	90.00	10	0.00	11.11	9	100.00	8
Mtl. Prot.					{ 4			{ 8		
Julius Rich.					{ 4	50.00	0.00	{ 8	12.50	8
Chldn's Cott. } Mtl. Convales. } ^j	20.00	80.00	20.00	40.00	{ 1 { 1			{		
<u>Category S5:</u>										
Maimonides	0.00	100.00	40.00	83.33	30	16.67	3.33	30	27.59	29
Hos. of Hope	20.00	80.00	40.00	70.00	10	12.50	0.00	8	25.00	8
Jewish Conva.	6.67	93.33	53.33	80.00	15	14.29	0.00	14	21.43	14
<u>Category S6:</u>										
Ste. Anne's	21.43	78.57	0.00	50.00	14	36.36	27.27	11	0.00	8
Total	7.72	92.28	37.39	77.15	337^l	16.40	2.89	311^l	22.52	302^l

Footnotes: see following page

TABLE B:17.--Continued

a to h^m These notes correspond to notes "a to h" in Table B:8.

iⁱ The relatively low proportion of non-certificated physicians on staff appears, on looking at the hospital list of staff physicians, to be due to a relatively high proportion of physicians with certification only by American specialty boards. This qualification was not coded by the Quebec College. We might note that all Canadian provinces except the maritimes do not regard such physicians as "specialists." This is discussed further in Appendix A, Physicians section. Information from Royal College.

j^j So as to conceal data on individual physicians and make percentages meaningful, these hospitals are treated together.

k^k The very high proportion of multi-specialists appears to be due, at the Catherine Booth maternity hospital, to the fact that obstetrics and gynecology used to be two specialties, and thus many older physicians would have double certification for what is now one specialty; and at the Royal Edward Chest hospital, to the fact that specialists in chest diseases and tuberculosis have traditionally often taken certification in internal medicine, also, while physicians with certification in thoracic surgery often take certification in general surgery as well. Information from Quebec College.

l^l See Table B:7 note "g."

TABLE B:18.--Physicians at special hospitals, showing proportions who are consultants, teachers, or researchers^a

Category and Hospital	Consultants ^b		Teachers		Researchers		N (100%)
	Per Cent	N (100%)	As Main Activity ^c	As Main, 2nd or 3rd Activity ^d	As Main Activity ^e	As Main, 2nd or 3rd Activity ^f	
ACUTE HOSPITALS	%		%	%	%	%	
Category S1: Children's Neuro	} 29.07	172	3.23	54.84	4.52	26.46	155
			21.05	100.00	5.26	52.63	19
Category S2: Royal Edward Douglas Alexandra	} 28.85	52	4.00	56.00	0.00	16.00	25
			}g 7.41	44.44	3.70	14.81	(24 (3
Category S3: Catherine B. Shriners	} 29.09	55	2.17	45.65	0.00	17.40	46
			10.00	80.00	0.00	30.00	10
CHRONIC/CONVA- LESCENT HOS.							
Category S4: Grace Dart Mtl. Prot. Julius Rich. Chldn's Cott. Mtl. Convales.	} 44.44	18	0.00	20.00	0.00	10.00	10
			}g 0.00	20.00	0.00	0.00	(4 (4 (1 (1
Category S5: Maimonides Hos. of Hope Jewish Conva.	} 25.49	51	0.00	13.34	0.00	30.00	30
			0.00	20.00	0.00	0.00	10
			0.00	26.66	0.00	20.00	15
Category S6: Ste. Anne's	14.29	14	0.00	21.43	0.00	7.14	14
Total	27.57	337 ^h	3.56	48.07	2.97	23.74	337 ^h

Footnotes: see following page

TABLE B:18.--Continued

a to f^f These notes correspond to notes "a to f" in Table B:9.

^gSo as to conceal data on individual physicians and make percentages meaningful, these hospitals are treated together.

^hSee Table B:7 note "g."

TABLE B:19.--Percentage distribution of physicians by special hospital and by office location^a

Category and Hospital	West Island				West Center	East Center	North/East Island	Ile Jésus	Envi-rons	Metropolitan Montreal		
	Far West	French West	West City	Total						Per Cent	N	
ACUTE HOSPITALS	%	%	%	%	%	%	%	%	%	%		
Category S1:												
Children's	5.16	0.65	34.19	40.00	50.32	1.29	3.87	1.29	3.23	100.00	155	
Neuro	0.00	0.00	5.26	5.26	94.74	0.00	0.00	0.00	0.00	100.00	19	
Category S2:												
Royal Edward	0.00	0.00	36.00	36.00	40.00	16.00	8.00	0.00	0.00	100.00	25	
Douglas	}b	0.00	66.67	74.07	22.22	0.00	3.70	0.00	0.00	100.00	(24	
Alexandra												(3
Category S3:												
Catherine B.	4.35	0.00	41.30	45.65	47.83	0.00	6.52	0.00	0.00	100.00	46	
Shriners	0.00	0.00	30.00	30.00	60.00	0.00	10.00	0.00	0.00	100.00	10	
CHRONIC/CONVA-LESCENT HOS.												
Category S4:												
Grace Dart	0.00	0.00	30.00	30.00	70.00	0.00	0.00	0.00	0.00	100.00	10	
Mtl. Prot.	}b	0.00	30.00	40.00	30.00	0.00	10.00	10.00	10.00	100.00	(4	
Julius Rich.												(4
Chldn's Cott.)												(1
Mtl.Convales.)												(1
Category S5:												
Maimonides	0.00	0.00	86.67	86.67	13.33	0.00	0.00	0.00	0.00	100.00	30	
Hos. of Hope	0.00	0.00	70.00	70.00	30.00	0.00	0.00	0.00	0.00	100.00	10	
Jewish Conva.	6.67	0.00	86.66	93.33	6.67	0.00	0.00	0.00	0.00	100.00	15	
Category S6:												
Ste. Anne's	57.14	0.00	28.57	85.71	7.14	7.14	0.00	0.00	0.00	100.00	14	
Total	6.53	0.30	43.02	49.85	41.84	2.08	3.56	0.89	1.78	100.00	337 ^c	

Footnotes: see following page

TABLE B:19.--Continued

^aSee Table B:10 note "a."

^bSee Table B:18 note "g."

^cSee Table B:7 note "g."

TABLE B:20.--Percentage distribution of physicians by type of hospital-staff affiliation and by ethnic origin

Type of Hospital-staff Affiliation ^e	English & Scottish ^a	Jewish ^b	Irish ^c	Other non-French ^d	French	Total	
						Per Cent	N
	%	%	%	%	%	%	
Attending	43.66	18.55 (20.93)	4.46	20.34 (1.89)	13.00	100.00	1,008
Unaffiliated	35.48	10.22 (10.22)	7.53	44.09 (3.77)	2.69	100.00	186
Partial Affiliation Only	44.77	17.91 (19.40)	2.99	29.85 (4.48)	4.48	100.00	67
Consulting Only	60.58	16.06 (16.79)	11.68	9.49 (0.73)	2.19	100.00	137
All Physicians	44.20	17.33 (19.17)	5.66	22.70 (2.12)	10.11	100.00	1,414 ^f

Footnotes: see following page

TABLE B:20.--Continued

a to d^a These notes correspond to "a to d" in Table B:7.

^e"Attending" are physicians with full staff privileges. "Unaffiliated" have no formal affiliation to an English Montreal hospital. "Partial Affiliation Only" are physicians with something less than full staff privileges. "Consulting Only" are physicians with consulting membership at an English Montreal hospital, but no attending or partial-affiliation membership. These types are discussed more fully in Appendix A, Hospitals section.

^fThis total includes physicians not distributed among the staff-type categories. These are physicians with both consulting and partial-affiliation membership but no attending-staff membership at an English Montreal hospital. They number 16 among the 1,414 total physicians in this study.

TABLE B:21.--Percentage distribution of physicians by type of hospital-staff affiliation and by specialization characteristics^a

Type of Hospital-Staff Affiliation ⁱ	Specialization		Royal College		N ^d (100%)	One Agency Only ^e			2 or More Certificates ^g	N ^h (100%)
	No Certificate	1 or More Certificates ^b	Fellowship	Total ^c		Quebec	Canada	N ^f (100%)		
	%	%	%	%		%	%		%	
Attending	15.97	84.03	35.62	69.95	1,008	16.77	3.78	847	21.97	815
Unaffiliated	67.20	32.80	4.84	19.89	186	39.34	14.75	61	7.69	52
Partial Affiliation Only	64.18	35.82	7.46	22.39	67	37.50	25.00	24	0.00	18
Consulting Only	19.71	80.29	35.04	73.00	137	9.09	10.91	110	19.39	98
All Physicians	25.32	74.68	29.77	61.10	1,414 ^j	18.18	5.59	1,056 ^j	20.46	997 ^j

^a to ^h These notes correspond to notes "a to h" in Table B:8.

ⁱ See Table B:20 note "e."

^j See Table B:20 note "f."

TABLE B:22.--Physicians by type of hospital-staff affiliation: showing proportions who are consultants, teachers, or researchers^a

Type of Hospital-staff Affiliation ^g	Consultants ^b	Teachers		Researchers		N (100%)
		As Main Activity ^c	As Main, 2nd, or 3rd Activity ^d	As Main Activity ^e	As Main, 2nd, or 3rd Activity ^f	
	%	%	%	%	%	
Attending	22.82	3.17	43.25	3.37	20.23	1,008
Unaffiliated	0.00	1.08	13.43	3.23	9.14	186
Partial Affiliation Only	0.00	0.00	19.41	2.99	10.45	67
Consulting Only	100.00	2.19	12.41	2.19	11.68	137
All Physicians	27.09	2.62	34.80	3.18	17.33	1,414 ^h

^{a to f} These notes correspond to notes "a to f" in Table B:9.

^g See Table B:20 note "e."

^h See Table B:20 note "f."

TABLE B:23.--Percentage distribution of physicians by type of hospital-staff affiliation and by office location^a

Type of Hospital-staff Affiliation ^b	West Island				West Center	East Center	North/East Island	Ile Jésus	Envi-rons	Metropolitan Montreal	
	Far West	French West	West City	Total						Per Cent	N
	%	%	%	%	%	%	%	%	%	%	
Attending	7.94	0.89	39.48	48.31	37.40	3.37	9.42	0.50	0.99	100.00	1,008
Unaffiliated	4.84	1.61	31.72	38.17	24.19	10.22	21.51	1.08	4.84	100.00	186
Partial Affiliation Only	16.42	1.49	43.28	61.19	20.90	7.46	7.46	0.00	2.99	100.00	67
Consulting Only	0.73	0.73	31.39	32.85	56.93	8.03	2.19	0.00	0.00	100.00	137
All Physicians	7.14	0.99	37.91	46.04	36.92	4.95	10.11	0.49	1.49	100.00	1,414 ^c

^aSee Table B:10 note "a."

^bSee Table B:20 note "e."

^cSee Table B:20 note "f."

APPENDIX C

DATA ON STAFF DUPLICATION AMONG ATTENDING PHYSICIANS

Note: A nil entry in these tables is indicated either
by "nil" or by "0.00."

TABLE C:1.--Percentage distribution of physicians by number of attending positions held and by medical-type of hospital; also showing total attending positions held and their number per 100 attending physicians

	Attending Physicians						All Physicians
	General Hospitals	Special Hospitals				All Hospitals	
		Total	Acute Special	Chronic/Convales.	Public		
	%	%	%	%	%	%	
<u>Number of Attending Positions Held:</u>							
One	61.70	28.78	29.46	17.39	64.29	64.29	45.83
Two	30.63	52.52	55.81	46.38	35.71	28.87	20.58
Three or More ^a	7.61	18.69	14.73	36.23	0.00	6.85	4.88
N (100%)	893	337	258	69	14	1,008	1,414 ^b
<u>Total Number of Attending Positions Held</u>	1,313	651	484	156	19	1,447	1,447
<u>Number of Attending Positions per 100 Physicians</u>	147.03	193.18	187.60	226.09	135.71	144.55	102.33

^aSixty-nine attending physicians hold three or more attending positions. At most only 10 of these physicians hold more than three positions.

^b28.71% of this total have no attending-staff affiliation.

TABLE C:2.--General-hospital categories, showing number of attending positions and attending physicians, number of partial-affiliation and consulting positions, and percentage of attending physicians with partial affiliation elsewhere^a

Category and Hospital	Attending ^b		Partial-Affiliation Positions ^c		Consulting Positions ^c	Attending Physicians with Partial Affiliation Elsewhere ^d	
	Positions	Physicians	Out Patient	Courtesy, Visiting		Out Patient	Courtesy, Visiting
<u>Category G1:</u> Royal Vic. Mtl. General	} 400	379	17	10	51	} 0.53	6.33
			43	3	60		
<u>Category G2:</u> Jewish Gen.	194	194	22	nil	61	4.12	11.86
<u>Category G3:</u> St. Mary's	82	82	7	46	15	6.10	13.41
<u>Category G4:</u> Queen Eliz. Reddy Mem.	} 153	148	4	17	26	} 13.51	16.22
			1	3	52		
<u>Category G5:</u> Lakeshore Gen. Lachine Gen.	} 128	105	19	nil	15	} 9.52	10.48
			7	nil	5		
<u>Category G6:</u> Bellechasse Doctors Eastern Mayfair Mount Royal	} 103	101	nil	59	17	} 0.99	9.90
			nil	23	5		
			nil	nil	2		
			nil	nil	nil		
			nil	nil	nil		
<u>Category G7:</u> Queen Mary	16	16	13	nil	130	6.25	nil
Total	1076	893	133	161	439	4.48	10.19

Footnotes: see following page.

TABLE C:2.--Continued

^aHospital-affiliation categories are described in Appendix A, Hospitals section.

^bThe difference between columns 1 and 2 is the number of duplicate positions within the category, resulting from physicians who are attending at more than one of the category's hospitals.

^cThese are the total positions of the particular type at each hospital that are held by physicians of metropolitan Montreal. There may be additional such positions held by physicians outside this region. Also some of these positions may be held by physicians of French Montreal, that is, physicians with French as their preferred language who have no attending-staff affiliation at an English hospital and are thus excluded from this study.

^d"Elsewhere" means at another hospital not another category. Thus physicians who are attending at the Royal Victoria and out-patient staff at the Montreal General are included in the out-patient column for Category G1.

TABLE C:3.--Special-hospital categories, showing number of attending positions and attending physicians, number of partial-affiliation and consulting positions, and percentage of attending physicians with partial affiliation elsewhere

Category and Hospital	Attending		Partial-Affiliation Positions		Consulting Positions	Attending Physicians with Partial Affiliation Elsewhere	
	Positions	Physicians	Out Patient	Courtesy, Visiting		Out Patient	Courtesy, Visiting
ACUTE HOSPITALS						%	%
<u>Category S1:</u>							
Children's Neuro	} 174	172	nil	nil	41	} 1.74	19.77
			nil	7	14		
<u>Category S2:</u>							
Royal Edward Douglas Alexandra	} 52	52	3	nil	34	} 11.54	1.92
			nil	nil	23		
			nil	nil	16		
<u>Category S3:</u>							
Catherine B. Shriners	} 56	55	nil	62	37	} 5.45	29.09
			nil	nil	9		
CHRONIC/CONVALESCENT HOS.							
<u>Category S4:</u>							
Grace Dart Mtl. Prot. Julius Rich. Chldn's Cott. Mtl. Convales.	} 20	18	nil	nil	5	} 11.11	nil
			nil	nil	nil		
			nil	nil	nil		
			nil	nil	2		
<u>Category S5:</u>							
Maimonides Hos. of Hope Jewish Conva.	} 55	51	nil	nil	nil	} 11.76	7.84
			nil	nil	6		
			nil	nil	16		
<u>Category S6:</u>							
Ste. Anne's	14	14	nil	nil	11	7.14	nil
Total	371	337	3	69	214	6.23	14.24

194

Note; The footnotes of Table C:2 apply to this table also.

TABLE C:4.--General-hospital categories, showing percentage distribution of attending physicians by number of attending positions held, showing number of attending positions per 100 attending physicians, and total attending positions held and the percentage of such held outside the category

Category and Hospital	Number of Attending Positions Held				Attending Positions Per 100 Physicians	Total Attending Positions Held	Percentage of Total Attending Positions Held that are Outside the Category ^a
	One	Two	Three or More	N (100%)			
Category G1: Royal Vic. Mtl. General	59.37	32.72	7.92	379	149.87	568	29.58
Category G2: Jewish Gen.	45.88	40.72	13.40	194	169.07	328	40.85
Category G3: St. Mary's	45.12	43.90	10.98	82	168.29	138	40.58
Category G4: Queen Eliz. Reddy Mem.	35.14	43.24	21.62	148	189.86	281	45.55
Category G5: Lakeshore Gen. Lachine Gen.	51.43	33.33	15.24	105	167.62	176	27.27
Category G6: Bellechasse Doctors Eastern Mayfair Mount Royal	81.19	13.86	4.95	101	123.76	125	17.60
Category G7: Queen Mary	75.00	25.00	0.00	16	125.00	20	20.00
Total	61.70	30.68	7.61	893	147.03	1,313	18.05

^a"Attending Positions Held that are Outside the Category" is the difference between "Total Attending Positions Held" in this table and "Attending Positions" in Table C:2 (or C:3).

TABLE C:5.--Special-hospital categories, showing percentage distribution of attending physicians by number of attending positions held, showing number of attending positions per 100 attending physicians, and total attending positions held and the percentage of such held outside the category

Category and Hospital	Number of Attending Positions Held				Attending Positions Per 100 Physicians	Total Attending Positions Held	Percentage of Total Attending Positions Held that are Outside the Category
	One	Two	Three or More	N (100%)			
ACUTE HOSPITALS	%	%	%				%
Category S1: Children's Neuro	} 26.16	61.05	12.79	172	188.95	325	46.46
Category S2: Royal Edward Douglas Alexandra	} 50.00	40.38	9.62	52	165.38	86	39.53
Category S3: Catherine B. Shriners	} 9.09	58.18	32.73	55	229.09	126	55.56
CHRONIC/CONVALESCENT HOS.							
Category S4: Grace Dart Mtl. Prot. Julius Rich. Chldn's Cott. Mtl. Convales.	} 27.78	44.44	27.78	18	205.56	37	45.95
Category S5: Maimonides Hos. of Hope Jewish Conva.	} 13.73	47.06	39.22	51	233.33	119	53.78
Category S6: Ste. Anne's	64.29	35.71	0.00	14	135.71	19	26.32
Total	28.78	52.52	18.69	337	193.18	651	43.01

Note: The C:4 footnote applies to this table also.

TABLE C:6.--General-hospital attending physicians by general-hospital category, showing percentage with attending-staff affiliation in the English-Montreal hospital categories

General-Hospital Category ^a and N (100%)	English-Montreal Hospital Category ^a										
	G1	G2	G3	G4	G5	G6	S1	S2	S3	S1 to S3	S4 and S5
N	%	%	%	%	%	%	%	%	%	%	%
G1 (379)	100.00	3.96	4.22	5.80	2.64	0.00	13.72	2.37	5.54	20.84	2.37
G2 (194)	7.73	100.00	2.06	13.40	1.03	5.15	15.46	1.03	0.52	17.01	20.10
G3 (82)	19.51	4.88	100.00	9.76	4.88	0.00	15.85	1.22	4.88	20.73	4.88
G4 (148)	14.86	17.57	5.41	100.00	4.73	3.38	11.49	4.05	10.81	25.68	10.81
G5 (105)	9.53	1.90	3.81	6.67	100.00	1.90	10.48	0.95	3.81	15.24	3.81
G6 (101)	0.00	9.90	0.00	4.95	1.98	100.00	1.98	0.00	0.00	1.98	3.96
G7 (16)	25.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total (893)	42.44	21.72	9.18	16.57	11.76	11.31	12.54	2.02	4.48	18.48	6.05

^aFor hospitals included in the categories see Tables C:4 and C:5.

Note: Percentages read horizontally and do not add up to 100% because of duplicate affiliation among categories.

TABLE C:7.--Special-hospital attending physicians by special-hospital category, showing percentage with attending-staff affiliation in the English-Montreal hospital categories

Special-Hospital Category ^a and N (100%)	English-Montreal Hospital Category ^a											
	G1	G2	G3	G4	G5	G6	G1 to G6	S1	S2	S3	S1 to S3	S4 and S5
N	%	%	%	%	%	%	%	%	%	%	%	%
ACUTE-HQS.												
S1 (172)	30.23	17.44	7.56	9.88	6.40	1.16	65.12	100.00	4.07	8.14	100.00	0.00
S2 (52)	17.31	3.85	1.92	11.54	1.92	0.00	34.62	13.46	100.00	3.85	100.00	7.69
S3 (55)	38.18	1.82	7.27	29.09	7.27	0.00	72.73	25.45	3.64	100.00	100.00	0.00
S1-S3 (258)	30.62	12.79	6.59	14.73	6.20	0.78	63.95	66.67	20.16	21.32	100.00	1.55
CHRONIC/CONVA.												
S4 (18)	33.33	5.56	22.22	16.67	5.56	5.56	66.67	0.00	5.56	0.00	5.56	100.00
S5 (51)	5.88	74.51	0.00	25.49	5.88	5.88	82.35	0.00	5.88	0.00	5.88	100.00
S4 & S5 (69)	13.04	56.52	5.80	23.19	5.80	5.80	78.26	0.00	5.80	0.00	5.80	100.00
S6 (14)	14.29	0.00	7.14	7.14	7.14	0.00	35.71	0.00	0.00	0.00	0.00	0.00
Total (337)	26.71	21.36	6.23	15.73	6.23	1.78	65.88	51.04	15.43	16.32	76.56	20.47

^aFor hospitals included in the categories see Tables C:4 and C:5.

Note: Percentages read horizontally and do not add up to 100% because of duplicate affiliation among categories.

TABLE C:8.--Physician/hospital categories showing number of physicians in the category,^a number of excluded physicians, and a description of physicians included in the category^a

Physician/hospital Category	Included Physicians	Excluded Physicians	Description of Physicians Included in the Category
<u>General Hospitals</u>			
G1	342	37	All Royal Vic. and Mont. Gen. phys. except 6 on staff at public, 15 at Jewish Gen., and 16 at St. Mary's hospitals.
G2A	125	69	Jewish Gen. phys. not on staff at a voluntary "Protestant" hospital.
G2B	69	125	Jewish Gen. phys. on staff at a voluntary "Prot." hos.
G3A	44	38	St. Mary's phys. not on staff at a voluntary "Prot." hos.
G3B	38	44	St. Mary's phys. on staff at a voluntary "Prot." hos.
G4	91	57	All Queen E. and Reddy Mem. phys. except those on staff at a hos. of G1, G2 or G3.
G5	84	21	All Lakeshore and Lachine Gen. phys. except those on staff at a hos. of G1, G2, G3 and G4.
G6	83	18	All proprietary hos. phys. except those on staff at a voluntary general or special hos. (G1 to G5 & S1 to S5).
<u>Special Hospitals</u>			
S1	71	101	Neuro. and Childrens' phys. except those on staff at a voluntary general hospital (G1 to G5). ^b
S2/3	33 ^c	72	Royal Ed., Douglas, Catherine Booth and Shriners' phys. except those on staff at a voluntary gen. hos. (G1 to G5), or a hos. of S1.
S4/5	13 ^d	56	Those chronic hos. phys. who are not on staff at a voluntary general or acute-special hospital (G1-G5 & S1-S3).
<u>Public Hospitals</u>			
G7/S6	30 ^e	nil	All public-hospital physicians.

Footnotes: see following page.

TABLE C:8.--Continued

^aThese are the categories used in Chapter V for an examination of the process of sorting physicians into different hospital categories.

^bThe physicians who are on staff both at the Neuro and at the Royal Victoria but not on staff at the Montreal General or one of the hospitals of G2, G3, G4, G5, are included. They were included because of the close functional ties between the Neuro and the Royal Victoria whereby nearly all (15 of 19) Neuro physicians are also on staff at the Royal Victoria. This category includes 13 Neuro physicians (10 at both Neuro and Royal Vic.) and 58 Childrens' physicians.

^cTwenty-eight on staff at S2 and 5 at S3.

^dSix at the Christian (S4) and 7 at the Jewish (S5) hospitals.

^eSixteen on staff at Queen Mary Veterans and 14 at Ste. Anne's. The public hospital physicians with duplicate affiliation are excluded from all categories except G7/S6.

APPENDIX D

BIRTHPLACE AND MEDICAL SCHOOL DATA

Note: A nil entry in these tables is indicated by "...."

APPENDIX D

BIRTHPLACE AND MEDICAL SCHOOL DATA

In these pages preliminary to the tables we discuss the differential prestige of Canadian medical schools, and the implications of our foreign birthplace and medical school categories, and present some notes on the tables explaining terms, categories and other details.

Medical Schools: Differential Prestige

There exists no ranking of Canadian medical schools according to quality.¹ However, there are certain indicators of the relative prestige of English Canadian medical schools.²

We might assert with some certainty that the faculties of medicine of McGill University and the University of Toronto have an elite standing among English-Canadian medical schools.

¹One physician interviewed reported hearing of such a study of American medical schools based upon comparative graduates' marks. It would be very difficult to get data to make a similar comparison for Canada since even the medical graduate is only told his pass or fail rating. Interview 1.

²The discussion that follows of medical school prestige excludes the French Canadian schools which are very hard to compare in prestige with the English Canadian, being largely within a different cultural system. While they are at least as old and large (in terms of first year enrolments) as McGill and Toronto, until recently they probably were not held in great prestige within the English-language community. Whereas 12% of attending physicians were trained there, only 4% of consulting only physicians (an older generation) were (see Table D:8). Their shortage of laboratory space, lack of money for equipment and lack of clinical research space (except for l'Université de Montréal which opened a Clinical Research Institute in 1967), as well as their lesser involvement in research generally, compared to McGill and Toronto, have been referred to in a recent article. The current improvements in their situation have also been mentioned. See "Canadian Medical Research," Journal of the American Medical Association, Vol. 200, No. 10 (June 5, 1967), p. 35, passim.

They are the oldest and the largest.¹ McGill in 1962/63 had applications nearly three times greater than any other Canadian school.² Their medical faculties share the prestige accorded to these two universities generally in Canada.³

Both universities place a great emphasis upon training in research and the production of teachers.⁴ They both carry on an outstanding amount of graduate work and research.⁵ They also have the best developed clinical research facilities.⁶

McGill was the first Canadian medical school to set up separate departments within the medical faculty, and this in spite of the Canadian Medical Association's general attitude at that time disapproving of specialism.⁷ McGill benefits from very generous endowments from the Rockefeller Foundation.⁸

¹Establishment dates are shown in Table D:8. In 1966-67 first-year enrolment at McGill was 133 and at Toronto 159. The next largest enrolment among English Canadian medical schools was at Alberta, 105. "Canadian Medical Research," op. cit., p. 23.

²J. A. MacFarlane et al., Medical Education in Canada, Study Prepared for the Royal Commission on Health Services (Ottawa: Queen's Printer, 1965), p. 69.

³Among the Canadian "economic elite," of the scientists and engineers who were born and educated in Canada, 65% attended McGill or Toronto. John Porter, The Vertical Mosaic, op. cit., p. 277.

⁴"Most of the full-time faculty members in the medical schools of the United States and Canada have been trained in one of these schools [a list of 8 American universities and McGill and Toronto]" J. A. MacFarlane et al., op. cit., p. 131.

⁵Although McGill and Toronto accounted for only 24.5% of first year enrolments in Canadian medical schools in 1966-67, "approximately half of the medical research done in Canada is concentrated in the universities of Toronto and McGill. Both schools have long traditions of research excellence and the scope and volume of their present efforts is comparable to that of many leading medical schools in the United States." "Research has grown, but outside of Toronto and McGill, it has not flourished." In 1965-66 "of the 6,401 persons engaged in some phase of research or research training, 2,521 (39.4%) were located at Toronto and McGill." "Canadian Medical Research," op. cit., p. 23, p. 22 and p. 25.

⁶"The dearth of clinical research facilities in Canada (excepting, of course, McGill, Toronto and their associated teaching hospitals) is due to . . .," "Canadian Medical Research," op. cit., p. 35.

⁷J. A. MacFarlane et al., op. cit., p. 140.

⁸See McGill University, Annual Report 1966.

The Royal Commission on Health Services reported that McGill and Toronto were the only Canadian medical schools with adequate medical libraries.¹

In view of the apparent elite position of Toronto and McGill we present statistics on each of these medical schools. They are not united in one category because it is necessary to show McGill separately since it is the only English Quebec medical school.

Foreign Birthplace and Medical School Categories

In view of the large number of countries represented by physicians' birthplaces and medical schools, we had to set up categories. We wanted these categories to reflect upon the physicians' social homogeneity or heterogeneity in relation to the English Montreal community. We felt this could best be accomplished by stressing the language component of the physician's background. The presumption is that the English-speaking physician has more homogeneity with English Montreal and is more readily assimilated to the English community and English medical community. Conversely the physician from non English-speaking countries has more heterogeneity and is less readily assimilated.

Countries classified as "English" are those in which English is the only language spoken by virtually the entire population. A possible exception among medical school countries is South Africa.² Among birthplace countries possible exceptions are again South Africa, and Jamaica, Trinidad, Tobago, Barbados, and other countries of the West Indies.³

In showing the countries of Western (excluding Britain and Ireland) and Eastern Europe separately we presume that

¹"There can be no doubt that the success or failure of a teaching and research programme is just as dependent on good libraries as it is on good laboratories and equipment. Yet holdings in only 2 of the 12 university medical libraries approach the size now generally accepted as necessary for the support of an expanding programme of graduate teaching and research." Canada. Royal Commission on Health Services 1965--
Volume II (Ottawa: Queen's Printer, 1965), p. 113.

²Classified as non English-speaking because Afrikaans is the first language used at the universities represented--Cape Town and Johannesburg. Information from the Trade Commission of South Africa.

³Although English is probably the major language of the West Indies we thought the presumed color factor would place West Indians more nearly on a footing with non English-speaking persons in terms of assimilation.

persons from the former are more readily assimilable into the charter community of English Montreal than persons from Eastern Europe. The reasons for this are first of all the greater historical and cultural similarity between Britain and Western Europe, and secondly because many Eastern Europeans are Jews and thus differ socially from the Protestant charter community.¹

Notes to the Tables

The following notes describe the birthplace and medical school categories used, and present other detailed information about the tables in this appendix.

Birthplace

"English Countries" and "English-speaking Countries" comprise "Britain" (the United Kingdom), and "Other English Countries" (the United States, the Republic of Ireland, New Zealand and Australia). Canada is excluded because shown separately.

"Non-English Countries" and "non English-speaking Countries" comprise all other areas.

Medical School

"French Canada" ("French") refers to l'Université de Montréal and l'Université Laval.

"Toronto" is the University of Toronto.

"Other" Canadian medical schools comprise the universities of Dalhousie, Queens, Ottawa, Western Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia. The last four make up "Western Canada."

"English Countries" refers to the universities of the same countries included in the birthplace category of that name. A maximum of 40 universities may be represented.

~~"Non-English Countries" comprises the universities of "Western and Eastern Europe" and all "Other" areas.~~

"Western Europe" comprises the universities of Austria, Belgium, France, Germany, Holland, Italy, Malta, Portugal, Spain and Switzerland. A maximum of 58 universities may be represented.

¹In the U.S.A. almost one-half of Eastern European immigrants between 1880 and 1914 were Jews. Peter I. Rose, They and We: Racial and Ethnic Relations in the United States (New York: Random House, 1964), p. 31.

"Eastern Europe" comprises the universities of Bulgaria, Czechoslovakia, Greece, Hungary, Poland, Rumania, the U.S.S.R. and Yugoslavia. A maximum of 29 universities may be represented.

"Other Foreign" or "other non-English countries" comprise the universities of all other areas. The Quebec College has code numbers for 29 universities in this category, but only 24 of the 346 foreign-trained physicians in this study are graduates of "other foreign" medical schools.

Details of the Tables

Nil

Four periods (....) are used to indicate a nil entry throughout these tables.

N's of Less than Ten

Percentage distributions are hardly significant where the N is less than ten. They are shown in the tables for the record only, to indicate in what cells the few physicians are located.

Addition of N's

The N's in Table D:1 add up to 876 rather than 872 as shown in Table D:2 sub-table General Hospitals. This is because 4 physicians are affiliated with both the Jewish and Catholic hospitals.

In Table D:2, attending-physician category N's exceed the number of total attending physicians by 11--made up of 10 physicians with affiliation at both the Neuro (S1) and the Royal Victoria (G1); and one physician affiliated at both the Ste. Anne's public hospital (G7 and S6) and St. Mary's (G3) (included inadvertently with the category G3A).

The sum of the attending, unaffiliated, partial affiliation only and consulting-only categories falls short of the total-physicians number by 16 physicians who have both consulting and partial affiliation but no attending affiliation. The career characteristics of these physicians are not shown separately in the statistics.

Abbreviations and Definitions

"Can." = Canada.

"All Eng." = all foreign English countries.

"English C's" = foreign English countries.

"Non-Eng. C's" = foreign non-English countries.

"Western E." = Western European countries.

"Eastern E." = Eastern European countries.

"Other Non-Eng." = other foreign non-English countries.

In Tables D:1, D:2 and D:10 the medical-school category, other non-English countries--that is other than Europe--is included in the "Total" non-English countries column but not shown separately (compare Table D:9).

"Immigrant Physicians" in Table D:7 means physicians who graduated from medical school and were born abroad.

TABLE D:1.--Percentage distribution of general-hospital physicians by medical school and birthplace, hospital category held constant

Birthplace	Canadian Medical Schools					Foreign Medical Schools				Total	
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total		Total
							Europe				
							Western	Eastern			
%	%	%	%	%	%	%	%	%	%		
Major Teaching: G1											
Canada:											
Quebec	2.92	36.84	1.46	2.63	43.86	1.17	0.29	....	0.58	1.75	45.61
Other Can.	0.58	16.37	4.10	11.40	32.46	1.75	....	....	....	1.75	34.21
Canada	3.51	53.22	5.55	14.03	76.32	2.92	0.29	....	0.58	3.51	79.82
Abroad:											
Britain	....	0.88	....	....	0.88	4.97	....	....	0.29	5.26	6.14
All Eng.	....	1.46	....	....	1.46	6.43	....	....	0.29	6.73	8.19
Non-English	0.29	3.51	....	0.88	4.68	1.75	3.22	1.75	5.56	7.31	11.99
Abroad	0.29	4.97	....	0.88	6.14	8.19	3.22	1.75	5.85	14.04	20.18
Total	3.80	58.19	5.55	14.92	82.46	11.11	3.51	1.75	6.43	17.54	100.00
N											N = 342
Partial Teaching, Jewish: G2A											
Canada:											
Quebec	5.60	52.00	0.80	4.00	62.40	2.40	4.00	....	4.00	6.40	68.80
Other Can.	....	5.60	4.00	1.60	11.20	0.80	....	....	....	0.80	12.00
Canada	5.60	57.60	4.80	5.60	73.60	3.20	4.00	....	4.00	7.20	80.80
Abroad:											
Britain	....	0.80	....	....	0.80	....	....	....	....	....	0.80
All Eng.	....	1.60	....	0.80	2.40	0.80	0.80	....	0.80	1.60	4.00
Non-English	0.80	1.60	....	2.40	4.80	0.80	6.40	1.60	9.60	10.40	15.20
Abroad	0.80	3.20	....	3.20	7.20	1.60	7.20	1.60	10.40	12.00	19.20
Total	6.40	60.80	4.80	8.80	80.80	4.80	11.20	1.60	14.40	19.20	100.00
N											N = 125

TABLE D:1.--Continued (1)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French	McGill	Toronto	Other	Total	English	Non-English Countries		Total	Total	
	Canada					Coun-	Europe				
						tries	Western	Eastern			
%	%	%	%	%	%	%	%	%	%		
Partial Teaching, Jewish: G2B											
Canada:											
Quebec	8.70	53.62	....	8.70	71.01	....	1.45	....	1.45	1.45	72.46
Other Can.	....	2.90	4.35	5.79	13.04	....	1.45	....	1.45	1.45	14.49
Canada	8.70	56.52	4.35	14.49	84.06	....	2.90	....	2.90	2.90	86.96
Abroad:											
Britain	....	1.45	....	....	1.45	....	....	....	....	....	1.45
All Eng.	....	1.45	1.45	....	2.90	1.45	....	....	....	1.45	4.35
Non-English	....	1.45	....	....	1.45	2.90	1.45	1.45	4.35	7.25	8.70
Abroad	....	2.90	1.45	....	4.35	4.35	1.45	1.45	4.35	8.70	13.04
Total	8.70	59.42	5.80	14.49	88.41	4.35	4.35	1.45	7.25	11.59	100.00
N											N = 69
Partial Teaching, Catholic: G3A											
Canada:											
Quebec	9.09	31.82	....	2.27	43.18	....	2.27	....	2.27	2.27	45.45
Other Can.	....	6.82	2.27	4.55	13.64	....	....	....	....	....	13.64
Canada	9.09	38.64	2.27	6.82	56.82	....	2.27	....	2.27	2.27	59.09
Abroad:											
Britain	....	....	....	....	....	2.27	....	....	....	2.27	2.27
All Eng.	....	2.27	....	2.27	4.55	6.82	....	....	....	6.82	11.36
Non-English	....	6.82	....	....	6.82	....	15.91	6.82	22.73	22.73	29.55
Abroad	....	9.09	....	2.27	11.36	6.82	15.91	6.82	22.73	29.55	40.91
Total	9.09	47.73	2.27	9.09	68.18	6.82	18.18	6.82	25.00	31.82	100.00
N											N = 44

TABLE D:1.--Continued (2)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French	McGill	Toronto	Other	Total	English	Non-English Countries		Total	Total	
	Canada					Coun-tries	Europe				
	%	%	%	%	%	%	Western	Eastern	%	%	
Partial Teaching, Catholic: G3B											
<u>Canada:</u>											
Quebec	....	42.11	....	....	42.11	....	....	....	....	....	42.11
Other Can.	....	13.16	....	13.16	26.32	....	....	....	....	....	26.32
Canada	....	55.26	....	13.16	68.42	....	....	....	....	....	68.42
<u>Abroad:</u>											
Britain	....	....	....	....	....	5.26	....	....	....	5.26	5.26
All Eng.	....	....	....	....	....	7.89	....	....	....	7.89	7.89
Non-English	....	5.26	....	....	5.26	2.63	7.89	7.89	15.79	18.42	23.68
Abroad	....	5.26	....	....	5.26	10.53	7.89	7.89	15.79	26.32	31.58
Total	....	60.53	....	13.16	73.68	10.53	7.89	7.89	15.79	26.32	100.00
N											N = 38
Partial Teaching, Other: G4											
<u>Canada:</u>											
Quebec	4.40	41.76	1.10	2.20	49.45	....	2.20	....	2.20	2.20	51.65
Other Can.	....	10.90	3.30	3.30	17.58	....	....	....	....	....	17.58
Canada	4.40	52.75	4.40	5.49	67.03	....	2.20	....	2.20	2.20	69.23
<u>Abroad:</u>											
Britain	....	....	....	....	....	1.10	....	....	....	1.10	1.10
All Eng.	....	1.10	....	....	1.10	2.20	....	....	....	2.20	3.30
Non-English	1.10	3.30	....	1.10	5.49	....	7.69	12.09	21.98	21.98	27.47
Abroad	1.10	4.40	....	1.10	6.59	2.20	7.69	12.09	21.98	24.18	30.77
Total	5.49	57.14	4.40	6.59	73.63	2.20	9.89	12.09	24.18	26.37	100.00
N											N = 91

TABLE D:1.--Continued (3)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total	
							Europe				
%	%	%	%	%	%	Western	Eastern	%	%	%	
Non-teaching: G5											
<u>Canada:</u>											
Quebec	9.52	26.19	....	4.76	40.48	....	2.38	....	2.38	2.38	42.86
Other Can.	4.76	7.14	1.19	8.33	21.43	....	....	....	....	....	21.43
Canada	14.29	33.33	1.19	13.10	61.90	....	2.38	....	2.38	2.38	64.29
<u>Abroad:</u>											
Britain	....	....	....	....	....	5.95	....	....	....	5.95	5.95
All Eng.	....	1.19	....	....	1.19	8.33	....	....	....	8.33	9.52
Non-English	....	2.38	1.19	....	3.57	....	10.71	10.71	22.62	22.62	26.19
Abroad	....	3.57	1.19	....	4.76	8.33	10.71	10.71	22.62	30.95	35.71
Total	14.29	36.90	2.38	13.10	66.67	8.33	13.10	10.71	25.00	33.33	100.00
N											N = 84
Proprietary: G6											
<u>Canada:</u>											
Quebec	54.22	6.02	....	3.61	63.86	....	4.82	1.20	6.02	6.02	69.88
Other Can.	1.20	....	....	....	1.20	....	....	....	....	....	1.20
Canada	55.42	6.02	....	3.61	65.06	....	4.82	1.20	6.02	6.02	71.08
<u>Abroad:</u>											
Britain	....	....	....	....	....	....	....	....	....	....	....
All Eng.	....	....	....	....	....	....	....	....	....	....	....
Non-English	3.61	3.61	....	....	7.23	....	6.02	14.46	21.69	21.69	28.92
Abroad	3.61	3.61	....	....	7.23	....	6.02	14.46	21.69	21.69	28.92
Total	59.04	9.64	....	3.61	72.29	....	10.84	15.66	27.71	27.71	100.00
N											N = 83

TABLE D:2.--Percentage distribution of all physicians by medical school and birthplace, hospital-affiliation category held constant

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total	
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total		Total
							Europe					
							Western	Eastern				
%	%	%	%	%	%	%	%	%	%	%		
General Hospitals: G1 - G6												
<u>Canada:</u>												
Quebec	9.63	36.81	0.80	3.44	50.69	0.80	1.84	0.11	2.06	2.87	53.56	
Other Can.	0.80	10.21	3.10	7.23	21.33	0.80	0.11	....	0.11	0.92	22.25
Canada	10.44	47.02	3.90	10.66	72.02	1.61	1.95	0.11	2.18	3.78	75.80	
<u>Abroad:</u>												
Britain	....	0.57	....	....	0.57	2.98	....	....	0.11	3.10	3.67
All Eng.	....	1.26	0.11	0.11	1.49	4.47	0.11	....	0.23	4.70	6.19
Non-English	0.69	3.21	0.11	0.80	4.82	1.15	5.73	5.28	12.04	13.19	18.00	
Abroad	0.69	4.47	0.23	0.92	6.31	5.62	5.84	5.28	12.27	17.89	24.20	
Total	11.12	51.49	4.13	11.58	78.33	7.22	7.80	5.39	14.45	21.67	100.00	
N											N = 872	
Special Hospitals: Major Teaching: S1												
<u>Canada:</u>												
Quebec	15.49	21.13	2.82	2.82	42.25	2.82	1.41	....	1.41	4.23	46.48
Other Can.	....	9.86	2.82	11.27	23.94	....	....	....	....	....	23.94
Canada	15.49	30.99	5.63	14.08	66.20	2.82	1.41	....	1.41	4.23	70.42
<u>Abroad:</u>												
Britain	....	4.23	....	....	4.23	7.04	....	....	....	7.04	11.27
All Eng.	....	4.23	....	....	4.23	11.27	....	....	....	11.27	15.49
Non-English	....	1.41	....	....	1.41	1.41	5.63	4.23	11.27	12.68	14.08
Abroad	....	5.63	....	....	5.63	12.68	5.63	4.23	11.27	23.94	29.58
Total	15.49	36.62	5.63	14.08	71.83	15.49	7.04	4.23	12.68	28.17	100.00	
N											N = 71	

TABLE D:2.--Continued (1)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total	
							Europe				
	Western		Eastern	%	%	%					
%	%	%	%				%	%			
Special Hospitals: Other Acute: S2 & S3											
<u>Canada:</u>											
Quebec	12.12	15.15	....	....	27.27	....	3.03	....	3.03	3.03	30.30
Other Can.	....	6.06	....	9.09	15.15	....	....	....	....	....	15.15
Canada	12.12	21.21	....	9.09	42.42	....	3.03	....	3.03	3.03	45.45
<u>Abroad:</u>											
Britain	....	....	....	....	....	9.09	....	....	....	9.09	9.09
All Eng.	....	....	....	....	....	9.09	....	....	....	9.09	9.09
Non-English	....	6.06	3.03	....	9.09	....	21.21	12.12	36.36	36.36	45.45
Abroad	....	6.06	3.03	....	9.09	9.09	21.21	12.12	36.36	45.45	54.55
Total	12.12	27.27	3.03	9.09	51.52	9.09	24.24	12.12	39.39	48.48	100.00
N											N = 33
Special Hospitals: Chronic: S4 & S5											
<u>Canada:</u>											
Quebec	23.08	30.77	....	....	53.85	....	....	....	....	....	53.85
Other Can.	....	15.38	7.69	....	23.08	....	....	....	....	....	23.08
Canada	23.08	46.15	7.69	....	76.92	....	....	....	....	....	76.92
<u>Abroad:</u>											
Britain	....	....	....	....	....	....	....	....	....	....	....
All Eng.	....	....	....	....	....	7.69	....	....	....	7.69	7.69
Non-English	....	7.69	....	....	7.69	....	7.69	....	7.69	7.69	15.38
Abroad	....	7.69	....	....	7.69	7.69	7.69	....	7.69	15.38	23.08
Total	23.08	53.85	7.69	....	84.62	7.69	7.69	....	7.69	15.38	100.00
N											N = 13

TABLE D:2.--Continued (2)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total	
							Europe Western	Eastern			
%	%	%	%	%	%	%	%	%	%	%	
Public Hospitals: G7 and S6											
<u>Canada:</u>											
Quebec	23.33	23.33	3.33	....	50.00	....	3.33	....	3.33	3.33	53.33
Other Can.	6.67	10.00	....	3.33	20.00	....	....	....	....	....	20.00
Canada	30.00	33.33	3.33	3.33	70.00	....	3.33	....	3.33	3.33	73.33
<u>Abroad:</u>											
Britain	....	....	....	....	....	....	....	....	....	....	....
All Eng.	....	....	....	....	....	....	....	....	....	....	....
Non-English	....	6.67	....	....	6.67	....	6.67	13.33	20.00	20.00	26.67
Abroad	....	6.67	....	....	6.67	....	6.67	13.33	20.00	20.00	26.67
Total	30.00	40.00	3.33	3.33	76.67	....	10.00	13.33	23.33	23.33	100.00
N											N = 30
Attending Physicians											
<u>Canada:</u>											
Quebec	10.71	34.72	0.99	3.08	49.50	0.79	1.88	0.10	2.08	2.88	52.38
Other Can.	0.89	10.12	2.98	7.24	21.23	0.69	0.10	....	0.10	0.79	22.02
Canada	11.61	44.84	3.97	10.32	70.73	1.49	1.98	0.10	2.18	3.67	74.40
<u>Abroad:</u>											
Britain	....	0.79	....	....	0.79	3.37	....	....	0.10	3.47	4.27
All Eng.	....	1.39	0.10	0.10	1.59	4.86	0.10	....	0.20	5.06	6.65
Non-English	0.60	3.37	0.20	0.69	4.86	1.09	6.25	5.65	13.00	14.09	18.95
Abroad	0.60	4.75	0.30	0.79	6.45	5.95	6.35	5.65	13.19	19.15	25.60
Total	12.20	49.60	4.27	11.11	77.18	7.44	8.34	5.75	15.38	22.82	100.00
N											N = 1008

TABLE D:2.--Continued (3)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total	
							Europe				
							Western	Eastern			
%	%	%	%	%	%	%	%	%	%	%	
Unaffiliated Physicians											
<u>Canada:</u>											
Quebec	3.76	29.03	0.54	5.38	38.71	1.08	2.69	....	2.69	3.76	42.47
Other Can.	1.08	5.38	2.69	5.38	14.52	....	....	....	....	....	14.52
Canada	4.84	34.41	3.23	10.75	53.23	1.08	2.69	....	2.69	3.76	56.99
<u>Abroad:</u>											
Britain	....	....	0.54	....	0.54	2.15	....	....	....	2.15	2.69
All Eng.	....	1.08	0.54	....	1.61	2.69	....	....	....	2.69	4.30
Non-English	....	2.69	....	0.54	3.23	1.61	13.44	15.59	33.87	35.48	38.71
Abroad	....	3.76	0.54	0.54	4.84	4.30	13.44	15.59	33.87	38.17	43.01
Total	4.84	38.17	3.76	11.29	58.06	5.38	16.13	15.59	36.56	41.94	100.00
N											N = 186
Physicians with Partial Affiliation Only											
<u>Canada:</u>											
Quebec	1.49	25.37	1.49	8.96	37.31	1.49	2.99	....	2.99	4.48	41.79
Other Can.	....	5.97	2.99	7.46	16.42	....	....	....	....	....	16.42
Canada	1.49	31.34	4.48	16.42	53.73	1.49	2.99	....	2.99	4.48	58.21
<u>Abroad:</u>											
Britain	....	2.99	....	....	2.99	2.99	....	....	....	2.99	5.97
All Eng.	....	4.48	....	....	4.48	5.97	....	....	....	5.97	10.45
Non-English	....	....	1.49	2.99	4.48	1.49	8.96	13.43	25.37	26.87	31.34
Abroad	....	4.48	1.49	2.99	8.96	7.46	8.96	13.43	25.37	32.84	41.79
Total	1.49	35.82	5.97	19.41	62.69	8.96	11.94	13.43	28.36	37.31	100.00
N											N = 67

TABLE D:2.--Continued (4)

Birthplace	Canadian Medical Schools					Foreign Medical Schools					Total
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total	Total	
							Europe				
							Western	Eastern			
%	%	%	%	%	%	%	%	%	%	%	
Physicians with Consulting Affiliation Only											
Canada:											
Quebec	2.92	59.85	....	1.46	64.23	1.46	2.19	0.73	2.92	4.38	68.61
Other Can.	0.73	16.06	2.19	5.11	24.09	....	....	....	....	....	24.09
Canada	3.65	75.91	2.19	6.57	88.32	1.46	2.19	0.73	2.92	4.38	92.70
Abroad:											
Britain	....	0.73	....	....	0.73	0.73	....	....	....	0.73	1.46
All Eng.	....	2.19	....	....	2.19	2.19	....	....	....	2.19	4.38
Non-English	....	....	....	0.73	0.73	....	1.46	0.73	2.19	2.19	2.92
Abroad	....	2.19	....	0.73	2.92	2.19	1.46	0.73	2.19	4.38	7.30
Total	3.65	78.10	2.19	7.30	91.24	3.65	3.65	1.46	5.11	8.76	100.00
N											N = 137
All English-Montreal Physicians											
Canada:											
Quebec	8.49	36.21	0.85	3.46	49.01	0.92	2.05	0.14	2.26	3.18	52.19
Other Can.	0.85	9.90	2.83	6.93	20.51	0.50	0.07	....	0.07	0.57	21.07
Canada	9.34	46.11	3.68	10.39	69.52	1.41	2.12	0.14	2.33	3.75	73.27
Abroad:											
Britain	....	0.78	0.07	....	0.85	2.90	....	....	0.07	2.97	3.82
All Eng.	....	1.56	0.14	0.07	1.77	4.31	0.07	....	0.14	4.46	6.22
Non-English	0.42	2.83	0.21	0.78	4.24	1.06	6.86	6.79	15.21	16.27	20.51
Abroad	0.42	4.38	0.35	0.85	6.01	5.37	6.93	6.79	15.35	20.72	26.73
Total	9.76	50.50	4.03	11.25	75.53	6.79	9.05	6.93	17.68	24.47	100.00
N											N = 1414

TABLE D:3.--Over- and under-representation^a of physicians with particular birthplace/medical school backgrounds (compared to all physicians) in general-hospital categories^b

Medical School	Hospital Category						N (100%)
	Major Teaching: G1	Partial Teaching			Non-Teaching: G5	Proprietary: G6	
		Jewish: G2A & G2B	Catholic: G3A & G3B	Other: G4			
	%	%	%	%	%	%	
Born in Quebec							
French Can.	-15.86	-2.89	-2.47	-3.11	+0.73	+31.63	120
McGill	+0.42	+6.21	+0.06	+0.98	-1.64	-4.89	512
Other Can.	-2.54	+5.96	-4.16	-1.52	+0.62	-0.95	61
Foreign	-10.86	+6.28	-3.58	-2.00	-1.50	+5.24	45
Born in Canada outside Quebec							
McGill	+15.81	-7.29	-0.09	+0.70	-1.65	-5.87	140
Can.Outside Quebec	+14.22	-3.58	....	-2.09	-0.14	-5.87	138
Born in Canada							
English C's	+25.81	+6.28	-5.80	-6.44	-5.94	-5.87	20
Non-Eng. C's	-18.13	+6.28	-2.70	-0.38	-0.12	+9.28	33
Born in Foreign English Countries							
English C's	+11.88	-10.44	+4.04	-3.16	+5.54	-5.87	61
Born in Foreign Non-English Countries							
McGill	+5.81	-6.22	+6.70	+1.06	-0.94	+1.63	40
Western E.	-12.85	-4.44	+4.51	+0.78	+3.34	-0.72	97
Eastern E.	-17.94	-10.60	+0.44	+5.02	+3.43	+6.63	96
Other Non-Eng.	-15.10	-0.08	-5.80	+2.65	-1.39	-1.32	22

^aIn percentage points.

^bThis table is based upon Table D:5. "All Physicians" are last row of D:5.

TABLE D:4.--Over- and under-representation^a of physicians with particular birthplace/medical school backgrounds (compared to all physicians) in hospital-affiliation categories^b

Medical School	Hospital-Affiliation Category									N (100%)
	Attending Physicians						Unaffiliated	Partial Affil. Only	Consulting Only	
	General Hos.: G1 - G6	Special Hospitals			Public Hos.: G7 & S6	Total (all attending)				
		Major Teach.: S1	Other Acute: S2 & S3	Chronic S4 & S5						
%	%	%	%	%	%	%	%	%		
Born in Quebec										
French Can.	+8.33	+4.15	+1.00	+1.58	+3.71	+18.71	-7.32	-3.91	-6.36	120
McGill	+1.03	-2.09	-1.35	-0.14	-0.75	-2.93	-2.60	-1.42	+6.33	512
Other Can.	-1.01	+1.54	-2.33	-0.92	-0.48	-4.08	+4.88	+6.74	-6.41	61
Foreign	-6.11	+1.65	-0.11	-0.92	+0.10	-6.85	+2.41	+1.93	+3.64	45
Born in Canada outside Quebec										
McGill	+1.90	-0.02	-0.90	+0.51	+0.02	+1.57	-6.01	-1.88	+6.02	140
Can. Outside Quebec	+3.55	+2.23	-0.16	-0.20	-1.40	+3.35	-2.28	+0.33	-2.44	138
Born in Canada										
English C's	+8.33	+4.98	-2.33	-0.92	-2.12	+3.71	-3.15	+0.26	+0.31	20
Non-Eng. C's	-4.09	-1.99	+0.70	-0.92	+0.91	-4.62	+2.00	+1.32	+2.43	33
Born in Foreign English Countries										
English C's	+2.26	+3.09	+2.59	+0.72	-2.12	+9.04	-4.95	+1.82	-4.77	61
Born in Foreign Non-English Countries										
McGill	+8.33	-2.52	+2.67	+1.58	+2.88	+13.71	-0.65	-4.74	-9.69	40
Western E.	-10.12	-0.90	+4.89	+0.11	-0.06	-6.34	+12.62	+1.45	-7.63	97
Eastern E.	-13.75	-1.90	+1.84	-0.92	+2.05	-11.92	+17.06	+4.63	-8.65	96
Other Non-Eng.	-20.76	-0.47	+2.22	-0.92	-2.12	-21.29	+27.76	+4.35	-9.69	22

^aIn percentage points.

^bThis table is based upon Table D:6. "All physicians" are last row of D:6.

TABLE D:5.--Percentage distribution^a of all physicians by general-hospital category for major categories of birthplace and medical school

Medical School	Hospital Category								N (100%)
	Major Teaching: G1	Partial Teaching					Non-Teaching: G5	Proprietary: G6	
		Jewish:		Catholic:		Other: G4			
		G2A	G2B	G3A	G3B				
%	%	%	%	%	%	%	%		
Born in Quebec									
French Can.	8.33	5.83	5.00	3.33	....	3.33	6.67	37.50	120
McGill	24.61	12.70	7.23	2.73	3.13	7.42	4.30	0.98	512
Other Can.	22.95	9.84	9.84	1.64	....	4.92	6.56	4.92	61
Foreign	13.33	17.78	2.22	2.22	....	4.44	4.44	11.11	45
Total	21.14	11.65	6.78	2.71	2.17	6.37	4.88	7.86	738
Born in Canada outside Quebec									
McGill	40.00	5.00	1.43	2.14	3.57	7.14	4.29	....	140
Can. Outside									
Quebec	38.41	5.07	5.07	2.17	3.62	4.35	5.80	....	138
Total	39.26	5.03	3.36	2.01	3.36	5.37	6.04	0.34	298
Born in Canada									
Canada	26.55	9.36	5.90	2.54	2.64	6.21	5.29	5.49	983
English C's	50.00	20.00	....	....	....	....	....	....	20
Non-Eng. C's	6.06	15.15	6.06	3.03	....	6.06	6.06	15.15	33
Total	26.35	9.75	5.79	2.51	2.51	6.08	5.21	5.69	1,036

TABLE D:5.--Continued

Medical School	Hospital Category								N (100%)
	Major Teaching: G1 %	Partial Teaching					Non-Teaching: G5 %	Proprietary: G6 %	
		Jewish:		Catholic:		Other: G4 %			
		G2A %	G2B %	G3A %	G3B %				
Born in Foreign English Countries									
English C's	36.07	1.64	1.64	4.92	4.92	3.28	11.48	....	61
Total	31.82	5.68	3.41	5.68	3.41	3.41	9.09	....	88
Born in Foreign Non-English Countries									
McGill	30.00	5.00	2.50	7.50	5.00	7.50	5.00	7.50	40
Western E.	11.34	8.25	1.03	7.22	3.09	7.22	9.28	5.15	97
Eastern E.	6.25	2.08	1.04	3.12	3.12	11.46	9.37	12.50	96
Other									
Non-Eng.	9.09	9.09	4.55	....	....	9.09	4.55	4.55	22
Total	14.14	6.55	2.07	4.48	3.10	8.62	7.59	8.28	290
Born in Foreign Countries									
McGill	27.42	6.45	3.23	6.45	3.23	6.45	4.84	4.84	62
Other Can.	17.39	21.74	4.35	4.35	....	8.69	4.35	13.04	23
Foreign	16.38	5.12	2.05	4.44	3.41	7.51	8.87	6.14	293
Total	18.25	6.35	2.38	4.76	3.17	7.41	7.94	6.35	378
All Birthplaces									
All Medical Schools	24.19	3.84	4.88	3.11	2.69	6.44	5.94	5.87	1,414

^aPercentages do not add up to the total general-hospital percentage shown in Table D:6 because of duplication among categories.

TABLE D:6.--Percentage distribution^a of all physicians by hospital-affiliation category for major categories of birthplace and medical school

Medical School	Hospital-Affiliation Category									N (100%)
	Attending Physicians						Unaffiliated	Partial Affil. Only	Consulting Only	
	General Hos.: G1 - G6	Special Hospitals			Public Hos.: G7 & G6	Total (all attending)				
		Major Teach.: S1	Other Acute: S2 & S3	Chronic: S4 & S5						
%	%	%	%	%	%	%	%	%		
Born in Quebec										
French Can.	70.00	9.17	3.33	2.50	5.83	90.00	5.83	0.83	3.33	120
McGill	62.70	2.93	0.98	0.78	1.37	68.36	10.55	3.32	16.02	512
Other Can.	60.66	6.56	....	....	1.64	67.21	18.03	11.48	3.28	61
Foreign	55.56	6.67	2.22	....	2.22	64.44	15.56	6.67	13.33	45
Total	63.28	4.47	1.36	0.95	2.17	71.54	10.70	3.79	12.74	738
Born in Canada outside Quebec										
McGill	63.57	5.00	1.43	1.43	2.14	72.86	7.14	2.86	15.71	140
Can. Outside Quebec	65.22	7.25	2.17	0.72	0.72	74.64	10.87	5.07	7.25	138
Total	65.10	5.70	1.68	1.01	2.01	74.50	9.06	3.69	11.07	298
Born in Canada										
Canada	63.89	4.78	1.42	1.02	3.14	72.53	10.07	3.66	12.31	983
English C's	70.00	10.00	....	....	....	75.00	10.00	5.00	10.00	20
Non-Eng. C's	57.58	3.03	3.03	....	3.03	66.67	15.15	6.06	12.12	33
Total	63.80	4.33	1.45	0.97	2.12	72.39	10.23	3.76	12.26	1,036

TABLE D:6.--Continued

Medical School	Hospital-Affiliation Category									N (100%)
	Attending Physicians						Unaffiliated	Partial Affil. Only	Consulting Only	
	General Hos.:	Special Hospitals			Public Hos.:	Total				
	G1 - G6	Major Teach. S1	Other Acute: S2 & S3	Chronic: S4 & S5	G7 & G6	(all attending)	%	%	%	
	%	%	%	%	%	%	%	%	%	
Born in Foreign English Countries										
English C's	63.93	13.11	4.92	1.64	....	80.33	8.20	6.56	4.92	61
Total	61.36	12.50	3.41	1.14	....	76.14	9.09	7.95	6.82	88
Born in Foreign Non-English Countries										
McGill	70.00	2.50	5.00	2.50	5.00	85.00	12.50	....	....	40
Western E.	51.55	4.12	7.22	1.03	2.06	64.95	25.77	6.19	2.06	97
Eastern E.	47.92	3.12	4.17	....	4.17	59.37	30.21	9.37	1.04	96
Other Non-Eng.	40.91	4.55	4.55	....	....	50.00	40.91	9.09	....	22
Total	54.14	3.45	5.17	0.69	2.76	65.86	24.83	7.24	1.38	290
Born in Foreign Countries										
McGill	62.90	6.45	3.23	1.61	3.23	77.42	11.29	4.84	4.84	62
Other Can.	69.57	....	4.35	....	....	73.91	8.69	13.04	4.35	23
Foreign	53.24	5.80	5.12	0.68	2.05	65.87	24.23	7.51	2.05	293
Total	55.82	5.56	4.76	0.79	2.12	68.25	21.16	7.41	2.65	378
All Birthplaces										
All Medical Schools	61.67	5.02	2.33	0.92	2.12	71.29	13.15	4.74	9.69	1,414

^aPercentages do not add up to the attending total or to 100% due to duplication among attending categories, and due to 16 physicians with partial and consulting affiliation but no attending affiliation who are not included in the table.

TABLE D:7.--Percentage distribution of all physicians by type of hospital-staff affiliation and birthplace

Type of Hospital-staff Affiliation	Born in Canada			Born Abroad				Immigrant Physicians, Born In:				N (100%)
	Quebec	Outside Quebec	Total	Britain	Other Eng. Countries	Non-Eng. Countries	Total	Britain	Other Eng. Countries	Non-Eng. Countries	Total	
	%	%	%	%	%	%	%	%	%	%	%	
Attending	52.38	22.02	74.40	4.27	2.38	18.95	25.60	3.47	1.59	14.09	19.15	1008
Unaffiliated	42.47	14.52	56.99	2.69	1.61	38.71	43.01	2.15	0.54	35.48	38.17	186
Partial Affiliation Only	41.79	16.42	58.21	5.97	4.48	31.34	41.79	2.99	2.99	26.87	32.84	67
Consulting Only	68.61	24.09	92.70	1.46	2.92	2.92	7.30	0.73	1.46	2.19	4.38	137
All Physicians	52.19	21.07	73.27	3.82	2.40	20.51	26.73	2.97	1.49	16.27	20.72	1414

TABLE D:8.--Percentage distribution of all physicians by type of hospital-staff affiliation and medical school--part one, Canadian medical schools

Type of Hospital-staff Affiliation	French Canada	McGill	Dalhousie	Queens	Toronto	Ottawa and Western Ontario	Western Canada	All Canada	N (100%)
	%	%	%	%	%	%	%	%	
Attending	12.20	49.60	2.08	2.78	4.27	3.17	3.08	77.18	1008
Unaffiliated	4.84	38.17	1.08	3.22	3.76	3.76	3.23	58.06	186
Partial Affiliation Only	1.49	35.82	5.97	10.45	5.97	....	2.99	62.69	67
Consulting Only	3.65	78.10	2.19	2.19	2.19	0.73	2.19	91.24	137
All Physicians	9.76	50.50	2.19	3.18	4.03	2.90	2.97	75.53	1414
Establishment Date of Medical Schools	U.of M. Laval 1843 1852	1829	1867	1854	1843	1945 1881	a		

^aManitoba 1883; Saskatchewan 1926; Alberta 1913; British Columbia 1949.

Source: Establishment dates: J. A. MacFarlane et al., Medical Education in Canada, Study Prepared for the Royal Commission on Health Services (Ottawa: Queen's Printer, 1965), p. 16.

TABLE D:9.--Percentage distribution of all physicians by type of hospital-staff affiliation and medical school--part two, foreign medical schools

Type of Hospital-staff Affiliation	English-speaking Countries				Non English-speaking Countries				All Foreign Countries	N (100%)	
	Britain	U.S.A.	Other	Total	Europe			Other			Total
					Western	Eastern	Europe				
%	%	%	%	%	%	%	%	%	%		
Attending	4.86	1.19	1.39	7.44	8.34	5.75	14.09	1.29	<u>15.38</u>	<u>22.82</u>	1008
Unaffiliated	4.30	0.54	0.54	5.38	16.13	15.59	31.72	4.84	<u>36.56</u>	<u>41.94</u>	186
Partial Affiliation Only	5.97	2.99	....	8.96	11.94	13.43	25.37	2.99	<u>28.36</u>	<u>37.31</u>	67
Consulting Only	2.19	1.46	....	3.65	3.65	1.46	5.11	....	<u>5.11</u>	<u>8.76</u>	137
All Physicians	4.53	1.20	1.06	6.79	9.05	6.93	15.98	1.70	17.68	24.47	1414

TABLE D:10.--Percentage distribution of physicians having both voluntary general (G1 to G5) and voluntary acute-special (S1 to S3) attending affiliation by medical school and birthplace

Birthplace	Canadian Medical Schools					Foreign Medical Schools				Total	
	French Canada	McGill	Toronto	Other	Total	English Coun- tries	Non-English Countries		Total		
							Europe				
						Western	Eastern				
	%	%	%	%	%	%	%	%	%	%	
Quebec	3.66	43.90	1.22	3.66	52.44	0.61	1.83	....	1.83	2.44	54.88
Other Can.	....	12.80	3.66	7.32	23.78	0.61	0.61	....	0.61	1.22	25.00
Canada	3.66	56.71	4.88	10.98	76.22	1.22	2.44	....	2.44	3.66	79.88
Britain	....	....	....	....	....	1.22	....	....	....	1.22	1.22
All Eng.C's	....	....	....	....	....	3.66	....	....	....	3.66	3.66
Non-Eng.C's	0.61	0.61	....	0.61	1.83	1.22	6.71	4.88	13.41	14.63	16.46
Abroad	0.61	0.61	....	0.61	1.83	4.88	6.71	4.88	13.41	18.29	20.12
Total	4.27	57.32	4.88	11.59	78.05	6.10	9.15	4.88	15.85	21.95	100.00
											N = 164

Note:

This table is presented for the suggestive comparison that can be made between this relatively advantageous practice setting and all attending physicians in Table D:2. Canadian-born physicians educated at McGill are better represented in the former (57% to 45%). Physicians educated in French Canada are relatively underrepresented (4% to 12%); as are those born abroad and educated in Canada (2% to 6%). There is the same proportion of physicians born and educated abroad (18% and 19%).

TABLE D:11.--Percentage distribution of general-hospital physicians born and educated (medical school) abroad, by hospital category and number of years in Canada--physicians born in English and non-English countries shown separately

Birthplace and Number of Years in Canada	Hospital Category								
	Major Teaching: G1	Partial Teaching				Other: G4	Non-Teaching: G5	Proprietary: G6	Total
		Jewish:		Catholic:					
		G2A	G2B	G3A	G3B				
	%	%	%	%	%	%	%	%	%
<u>English Countries:</u>									
Under 10	39.13	....	100.00	33.33	....	50.00	28.57	....	34.15
Under 15	73.91	....	100.00	33.33	33.33	100.00	57.14	....	63.41
Under 20	95.65	....	100.00	100.00	66.67	100.00	100.00	....	90.24
20 and over	4.35	100.00	....	....	33.33	....	....	....	9.76
N(100%)	23	2	1	3	3	2	7	....	41
<u>Non-English Countries:</u>									
Under 10	12.00	30.77	20.00	....	....	10.00	5.26	16.67	12.17
Under 15	72.00	46.15	40.00	20.00	57.14	65.00	57.89	55.56	57.39
Under 20	92.00	76.92	100.00	90.00	100.00	100.00	100.00	94.44	93.91
20 and over	8.00	23.08	....	10.00	....	....	....	5.56	6.09
N(100%)	25	13	5	10	7	20	19	18	115

See notes following Table D:12.

TABLE D:12.--Percentage distribution of all physicians born and educated (medical school) abroad by hospital-affiliation category and number of years in Canada--physicians born in English and non-English countries shown separately

Birthplace and Number of Years in Canada	Hospital-Affiliation Category									
	A & Both Gen. & Acute Special	Attending Physicians Special Hospitals			Public Hos.: G7 & S6	Total (all attending)	Unaffiliated	Partial Affil. Only	Consul-ting Only	Total
		Major Teach.: S1	Other Acute: S2 & S3	Chronic: S4 % S5						
	%	%	%	%	%	%	%	%	%	
<u>English Countries:</u>										
Under 10	33.33	37.50	....	100.00	....	33.33	....	25.00	33.33	30.16
Under 15	83.33	87.50	100.00	100.00	....	68.63	80.00	75.00	66.67	69.84
Under 20	83.33	100.00	100.00	100.00	....	92.16	100.00	100.00	66.67	92.06
20 and over	16.67	....	....	....	....	7.84	....	....	33.33	7.94
N(100%)	6	8	3	1	....	51	5	4	3	63
<u>Non-English Countries:</u>										
Under 10	8.33	44.44	25.00	....	....	14.79	13.64	16.67	....	14.35
Under 15	62.50	77.78	50.00	100.00	16.67	57.04	46.97	50.00	66.67	53.48
Under 20	95.83	88.89	83.33	100.00	100.00	92.96	93.94	88.89	66.67	92.61
20 and over	4.17	11.11	16.67	....	....	7.04	6.06	11.11	33.33	7.39
N(100%)	24	9	12	1	6	142	66	18	3	230

See notes on following page.

Notes to Tables D:11 and D:12:

The general-hospital and hospital-affiliation ("affiliation" below) categories are defined as in Tables D:1 and D:2 (categories described in Appendix C Table C:8).

Column 1 in Table D:12 refers to the physicians (shown in Table D:10) having attending affiliation at both a voluntary general and a voluntary acute-special hospital.

We might assume that it would be easier for newly-arrived immigrant physicians to gain affiliation at the lesser prestige affiliation categories. An examination of these tables, however, shows little association between length of time in Canada and prestige of affiliation category. There is, on the other hand, a pattern--fairly consistent among affiliation categories--associated with birthplace. Physicians born in English countries appear to gain affiliation sooner after arrival in Canada than physicians born in non-English countries. Interestingly enough, where this trend is reversed, it is associated with the lesser prestige or more restricted orbit of the practice setting--see the categories, unaffiliated, Jewish only (G2A), major teaching special (S1), and other-acute special (S2 and S3). Thus the association is stronger between birthplace and prestige of the affiliation category, than between affiliation category and time allowed for assimilation.

APPENDIX E

MAPS AND POPULATION TABLES: MONTREAL

Note: A nil entry in the two tables of the "Introductory Notes" is indicated by "0" or "0.00."

APPENDIX E

MAPS AND POPULATION TABLES

Introductory Notes

Maps 1 to 5 illustrate the organized areas of metropolitan Montreal; the statistical areas used to identify physicians' office locations and the distribution of the Montreal population; the location of English-Montreal hospitals by hospital type; and the relation of the two central statistical areas to the city-center.

The four major statistical areas on the island of Montreal are administrative areas. They represent single electoral districts of the Quebec College (North/East Island is two such districts combined. The dividing line runs approximately along Sherbrooke Street, along the length of the island, therefore). Their use as statistical areas is, thus, not ideal. It would have been preferable to examine physicians' office locations by municipality on Montreal Island. This information was not complete, however, for physicians with offices within the numbered postal-zone area of Montreal. The Quebec College coded "Montreal city" for a physician who gave his address as "Montreal 6" and Westmount for a physician who gave his address as "Westmount." Montreal 6 and Westmount are the same area, one the numbered postal-zone and the other the municipality. Since postal zones do not extend West of Verdun, Montreal West, Côte St. Luc, or St. Laurent, it was possible to identify reliably physicians' offices located in the Far West ("lakeshore") municipalities,--in the largely-French cities of the West end--Lachine, Lasalle, and Ville St. Pierre--and residually in West City. Since there is only one non-numbered postal-zone municipality in North/East Island--the heavily-French Pointe-aux-Trembles--it was not possible to do the same thing for the 10% of English-Montreal physicians with offices in North/East Island.

Having stated the drawbacks, the use of these particular administrative areas for our statistical purposes is not without considerable merit. The split between West Island and North/East Island does represent differing ethnic/linguistic preponderances. West Island is 59% non-French Canadian; North/East Island is 78% French Canadian. Within West Island, the "lakeshore" Far West is 71% non-French and West City 59% non-French (Table E:2). Forty-two per cent of the West Island population speak English only (59% in Far West), while 50% of the North/East Island population speak French only (Table E:4).

West Center and East Center cover an area of great ethnic heterogeneity in Montreal, both 50% French and non-French. In West Center, the dominant non-French category is British Isles; in East Center it is the heterogeneous "Other Non-French."

West Center and East Center both overlap the "city-center" as determined by the City of Montreal Planning Department. Thus they serve to indicate the concentration of physicians close to the financial, commercial and artistic core of the City. They also serve to show the heavy concentration of English hospitals about the city-center.

West Center and East Center are suitable, if not ideal, statistical areas to use in examining the location of physicians' offices. With certain qualifications, I believe it would be generally accepted that West Island and North/East Island outline very well the areas wherein are concentrated, on the one hand, the English-speaking population and, on the other hand, the French-speaking.

For these reasons, and because of the impossibility of recoding each physician's address, we used the Quebec College's primarily administrative areas for statistical purposes.

We should look at the ethnic/linguistic homogeneity of the statistical areas used. The following table presents the number of census tracts with a non French-Canadian majority, within each statistical area. We presume that non French-Canadians are a good indicator of English-speaking Montrealers.

Statistical Area	Census Tracts or Divisions with non French-Canadian Majority	Total Census Tracts or Divisions
Far West	10	13
French West	3	14
West City	56	84
(Westmount)	(7)	(7)
(Verdun)	(8)	(17)
West Center	12	19
East Center	18	34
North/East Island	7	162
(Mount Royal)	(3)	(3)
Ile Jésus	0	18
South Shore Environs	4	32
West Environs	0	6
North Environs	2	4
East Environs	0	2

Thus, while most tracts in Far West and West City have a majority non-French, the city of Verdun is an exception. And, while North/East Island has nearly all French-Canadian census tracts, Mount Royal has no French-Canadian census tracts. These are the two major exceptions to the general ethnic homogeneity of the statistical areas used.

We can learn considerably more about the precise locations of physicians within West City, West Center, East Center and North/East Island from the work of Guy Demers in 1964 ("Appartenance Ethnique et Réussite Professionnelle des Médecins du Grand Montréal," op. cit.). For physicians in private practice--excluding full-time employees of universities, government, or industry; and non-clinical specialists, that is radiologists, pathologists, anesthesiologists, biochemists and bacteriologists--he coded each physician's office address. He found five small areas in Montreal where 100 or more physicians had their offices. He established the area of uniformly-high population density in Montreal--comprising the first five concentric zones shown on Map 5 (zone 1 is the city-center). Within that region he showed the five areas of physician concentration. Everything outside of zones 1 to 5 he called the suburbs. The following table shows the percentage distribution of all Montreal physicians in private practice in 1964 by ethnic origin and by office location. The census tracts comprised within the five areas of concentration are listed after the table.

Important to note is that the area of heaviest physician concentration within West Center is smaller than the total area. While the Jewish General and St. Mary's physicians who are concentrated within West City are probably really located in large part within area 2. There are, this table suggests, comparatively few English Montreal physicians within Areas 3 to 5.

Readers who would like to examine in greater detail the locations of the ethnic populations within Montreal, and of the English hospitals in relation to the French, are referred to the fine set of maps prepared by Guy Demers (op. cit., pp. 111 to 126). These show the locations of all Montreal hospitals in 1963; the locations of all Montreal physicians' offices in 1964; and the ethnic character of Montreal census tracts in 1961.

Office Location	Ethnic Origin				Total	
	French	British	Jewish	Others	Per Cent	N
	%	%	%	%	%	
Areas of Concentration:						
Area 1	2.81	52.10	27.88	24.07	17.83	420
Area 2	4.11	10.63	37.61	16.18	9.93	234
Area 3	15.32	1.00	0.00	2.49	9.51	224
Area 4	10.86	0.20	0.88	4.15	6.96	164
Area 5	6.47	0.00	2.21	5.39	4.58	108
Areas 1 to 5	39.57	63.93	68.58	52.28	48.81	1,150
Other Areas within Concentric Zones 1 to 5	30.00	22.85	25.23	31.95	28.23	665
Suburbs	30.43	13.22	6.19	15.77	22.96	541
Total	100.00	100.00	100.00	100.00	100.00	2,356
N	1,390	499	226	241	2,356	-
Number of Non-clinical Specialists	206	58	15	43	322	-
Full-time Employees	215	108	18	49	390	-

Source: Guy Demers, "Appartenance Ethnique et Réussite Professionnelle des Médecins du Grand Montréal" (unpublished M.A. thesis, l'Université de Montréal, 1965), pp. 106, 109, and 129.

Note:

Area 1: census tracts 56 (northern half), 57, 58, 59, 118 (the un-numbered tract in West Center with 6 hospitals; see Map 5).

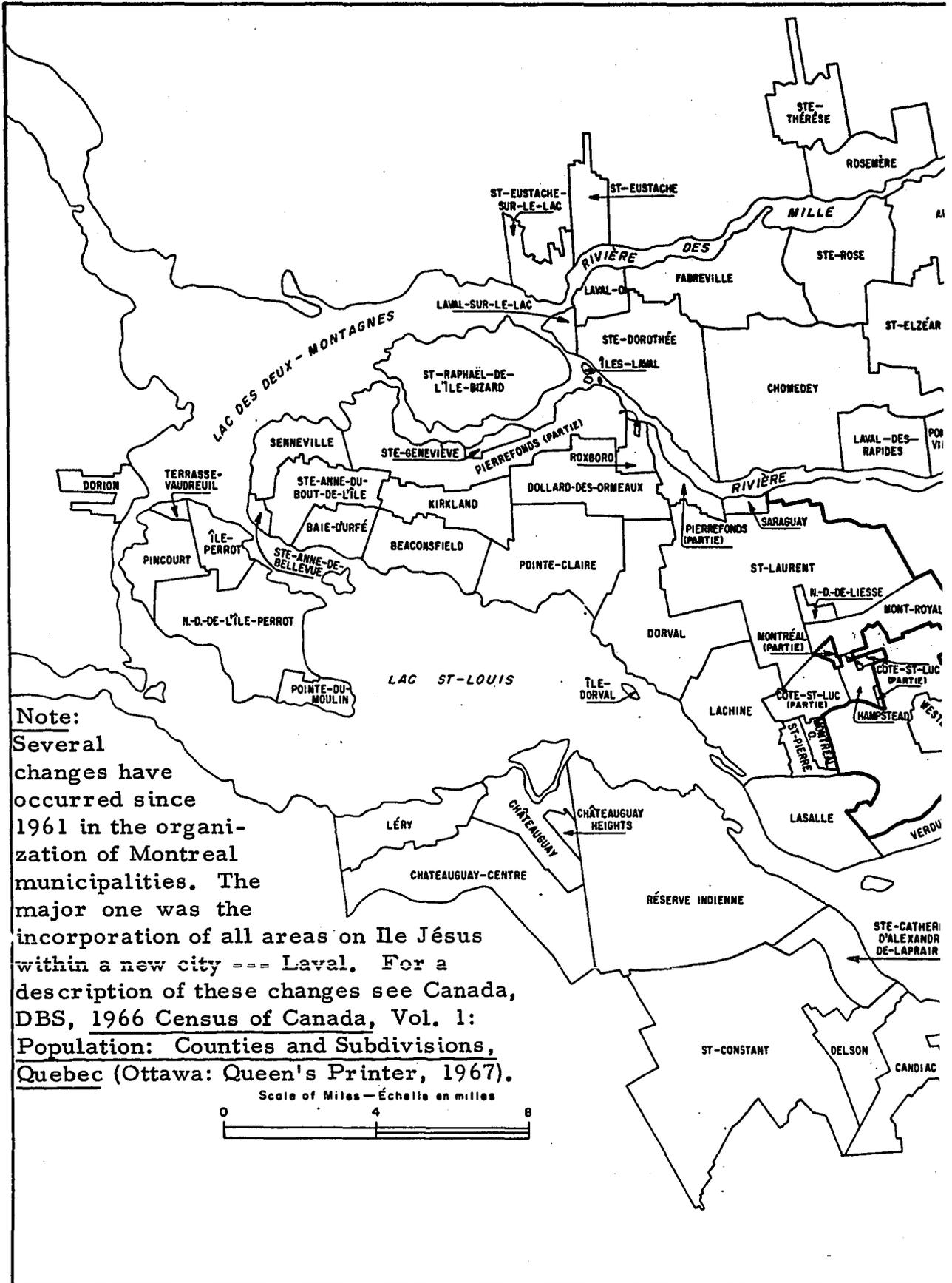
Area 2: census tracts 101, 105, 106, 107, 114, 117.

Area 3: census tracts 37, 38, 48, 138, 139, 154, 155.

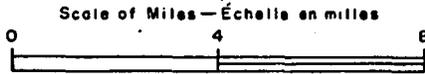
Area 4: census tracts 47, 48, 49, 124, 131, 132, 144, 145, 146.

Area 5: census tracts 187 to 190, 192 to 195, 204, 212 to 221, and 223.

The locations of these census tracts are shown on Map 5.

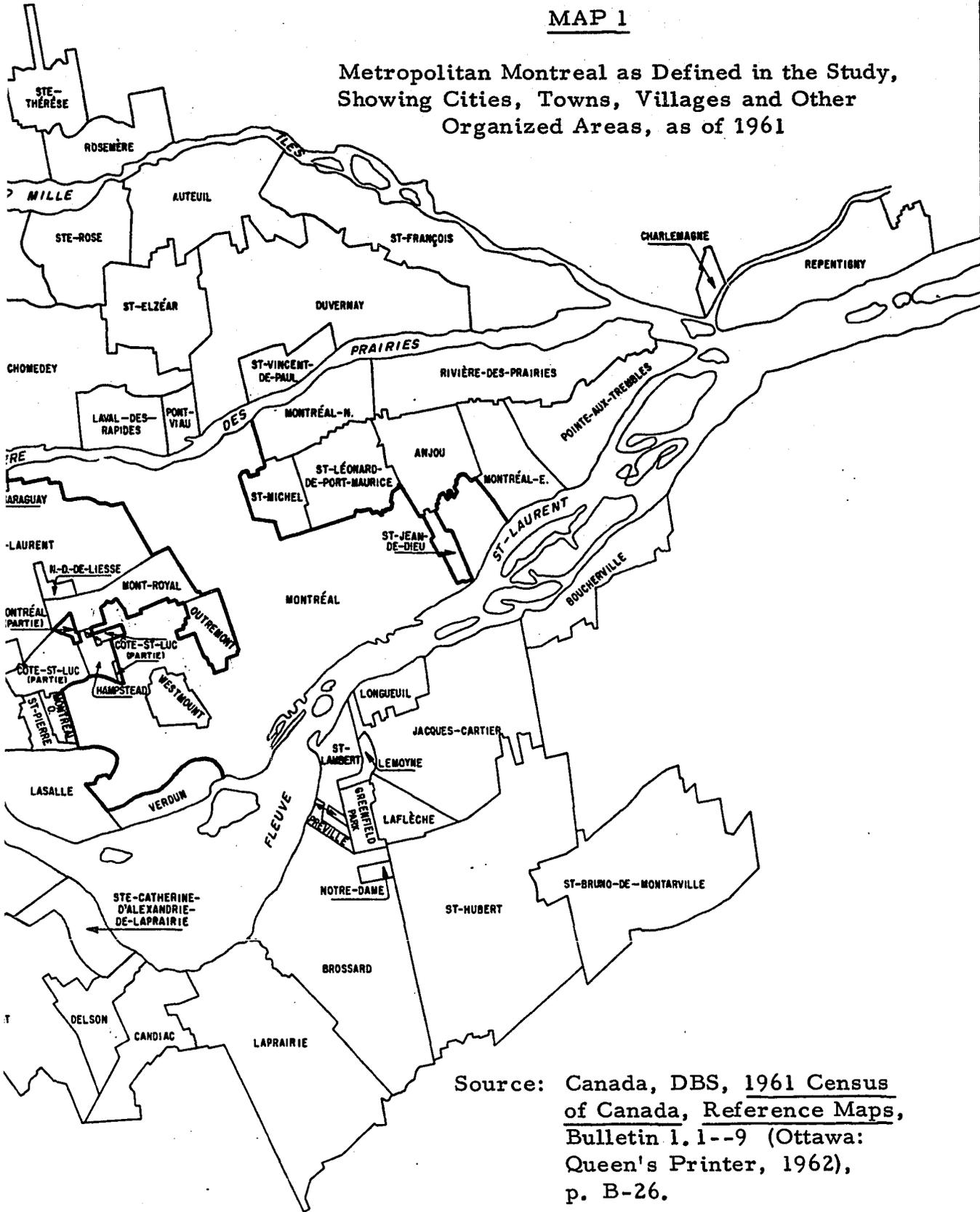


Note:
 Several changes have occurred since 1961 in the organization of Montreal municipalities. The major one was the incorporation of all areas on Ile Jésus within a new city --- Laval. For a description of these changes see Canada, DBS, 1966 Census of Canada, Vol. 1: Population: Counties and Subdivisions, Quebec (Ottawa: Queen's Printer, 1967).

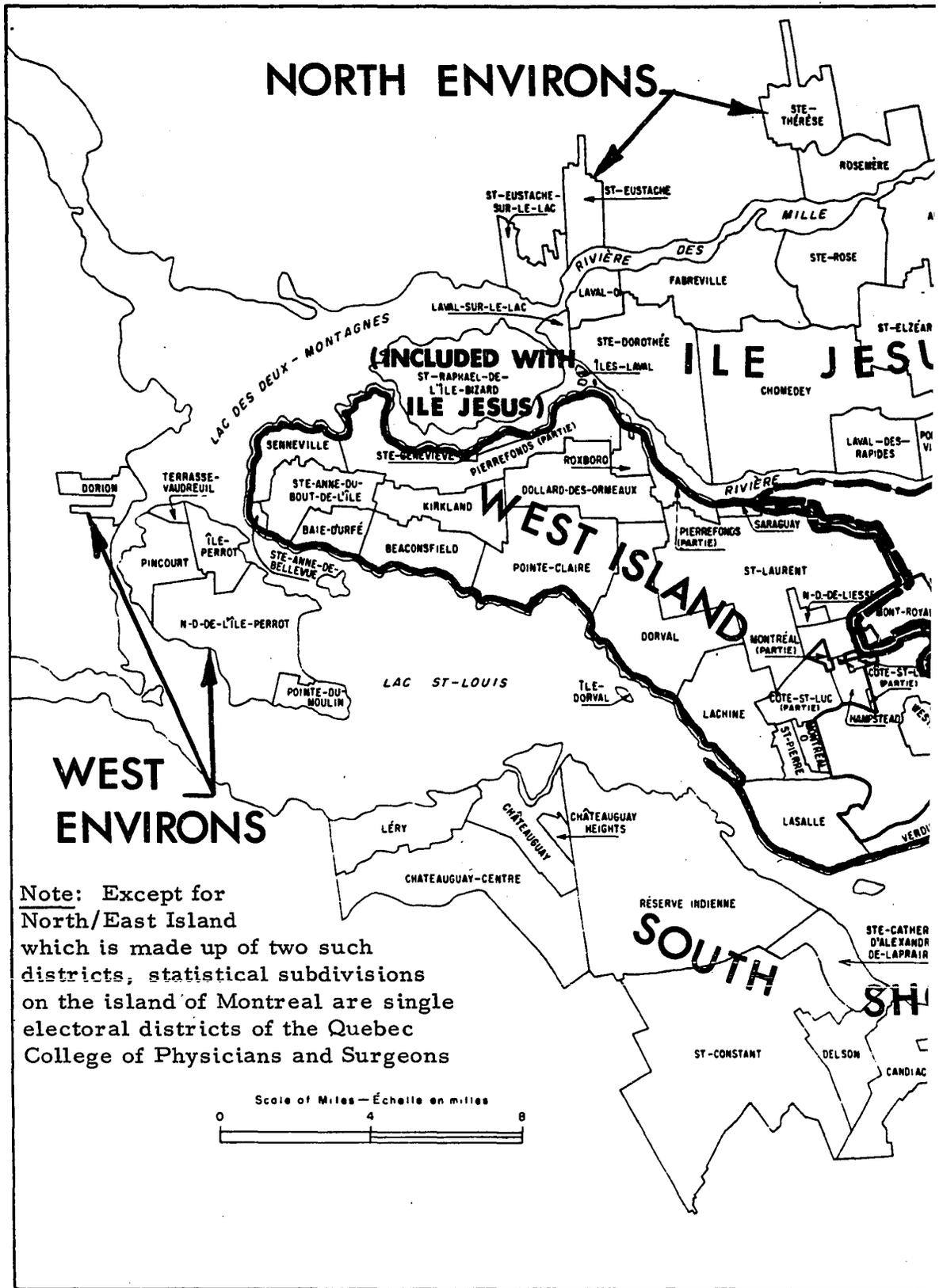


MAP 1

Metropolitan Montreal as Defined in the Study,
Showing Cities, Towns, Villages and Other
Organized Areas, as of 1961



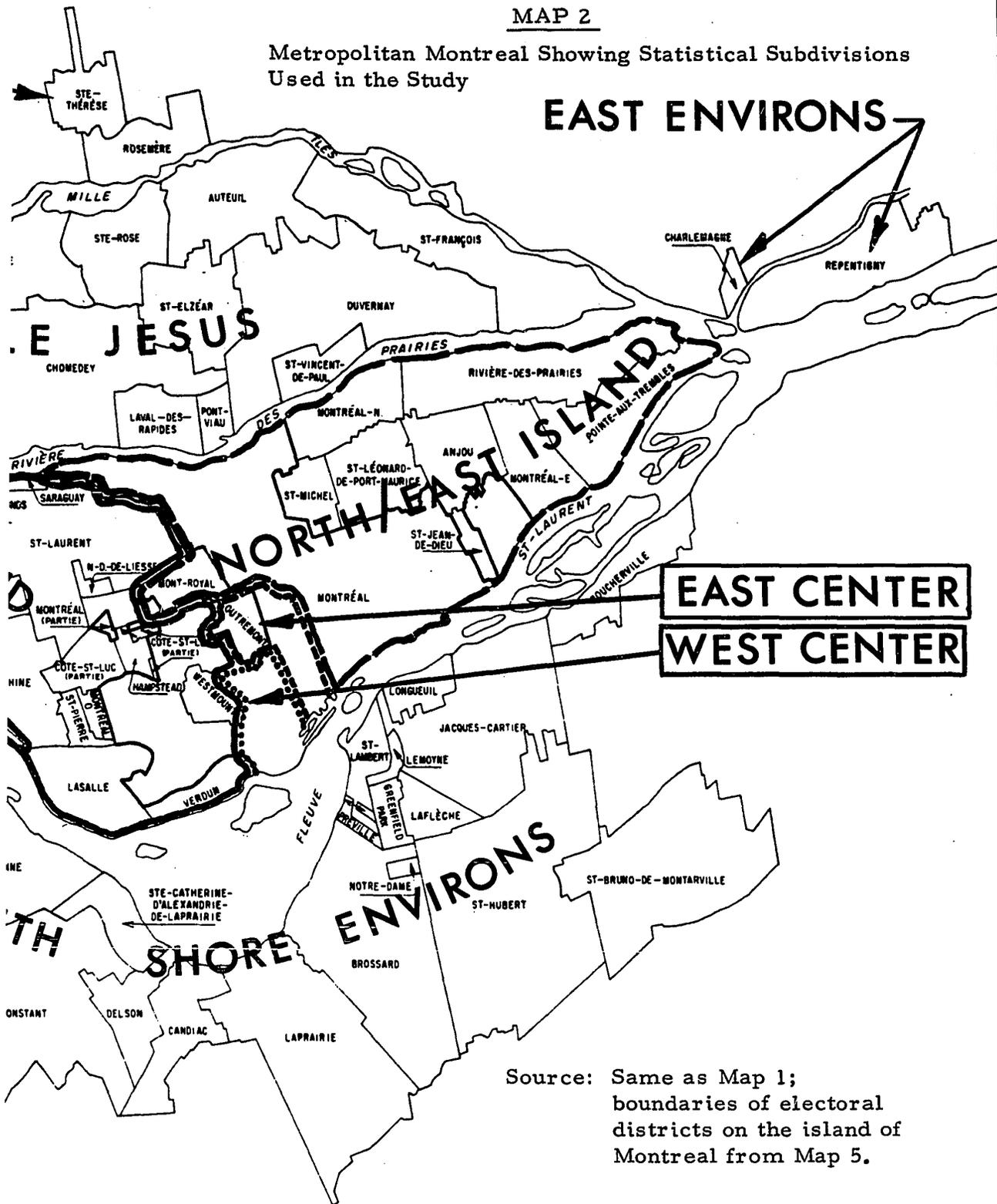
Source: Canada, DBS, 1961 Census
of Canada, Reference Maps,
Bulletin 1.1--9 (Ottawa:
Queen's Printer, 1962),
p. B-26.



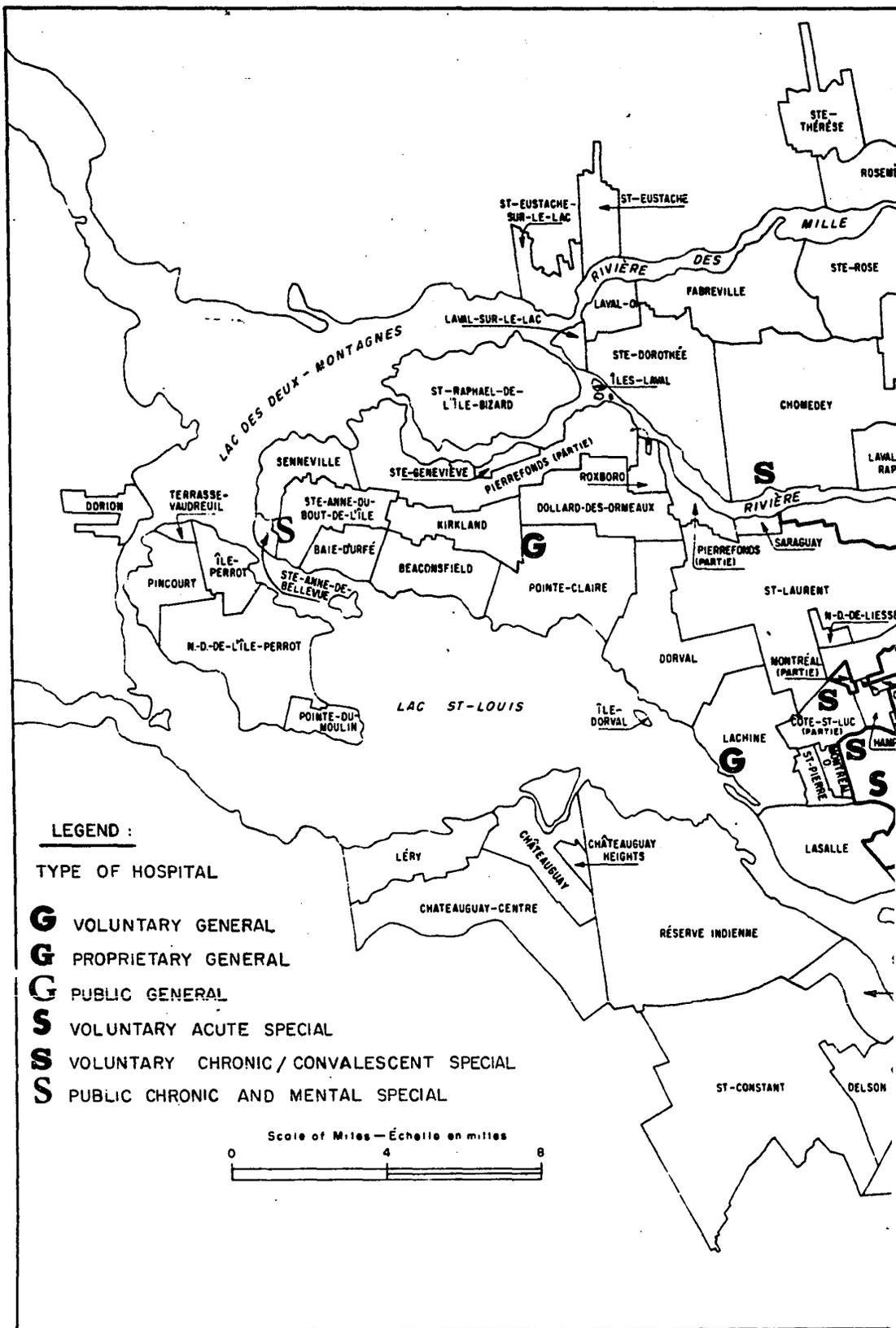
MAP 2

Metropolitan Montreal Showing Statistical Subdivisions
Used in the Study

EAST ENVIRONS

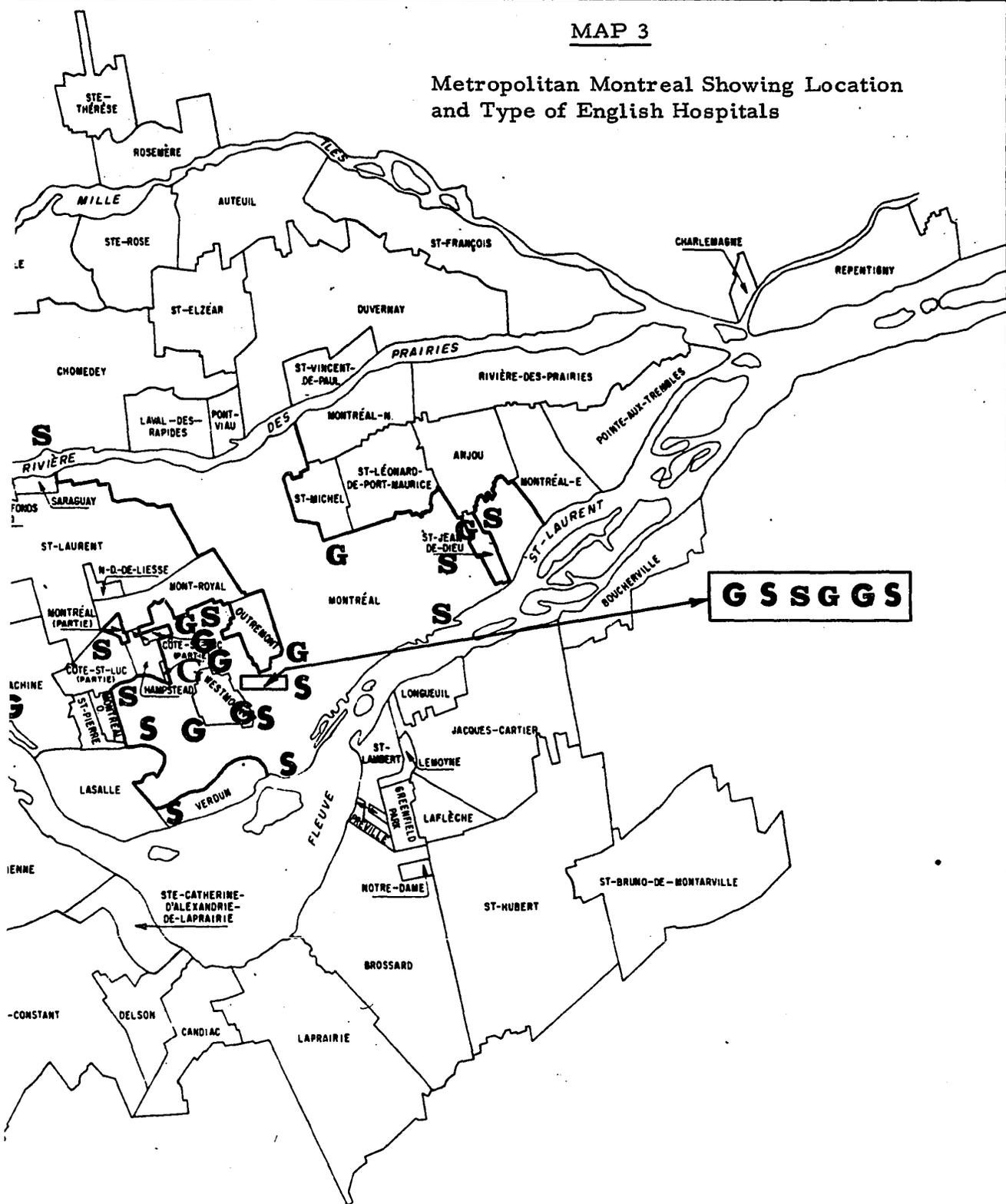


Source: Same as Map 1;
boundaries of electoral
districts on the island of
Montreal from Map 5.

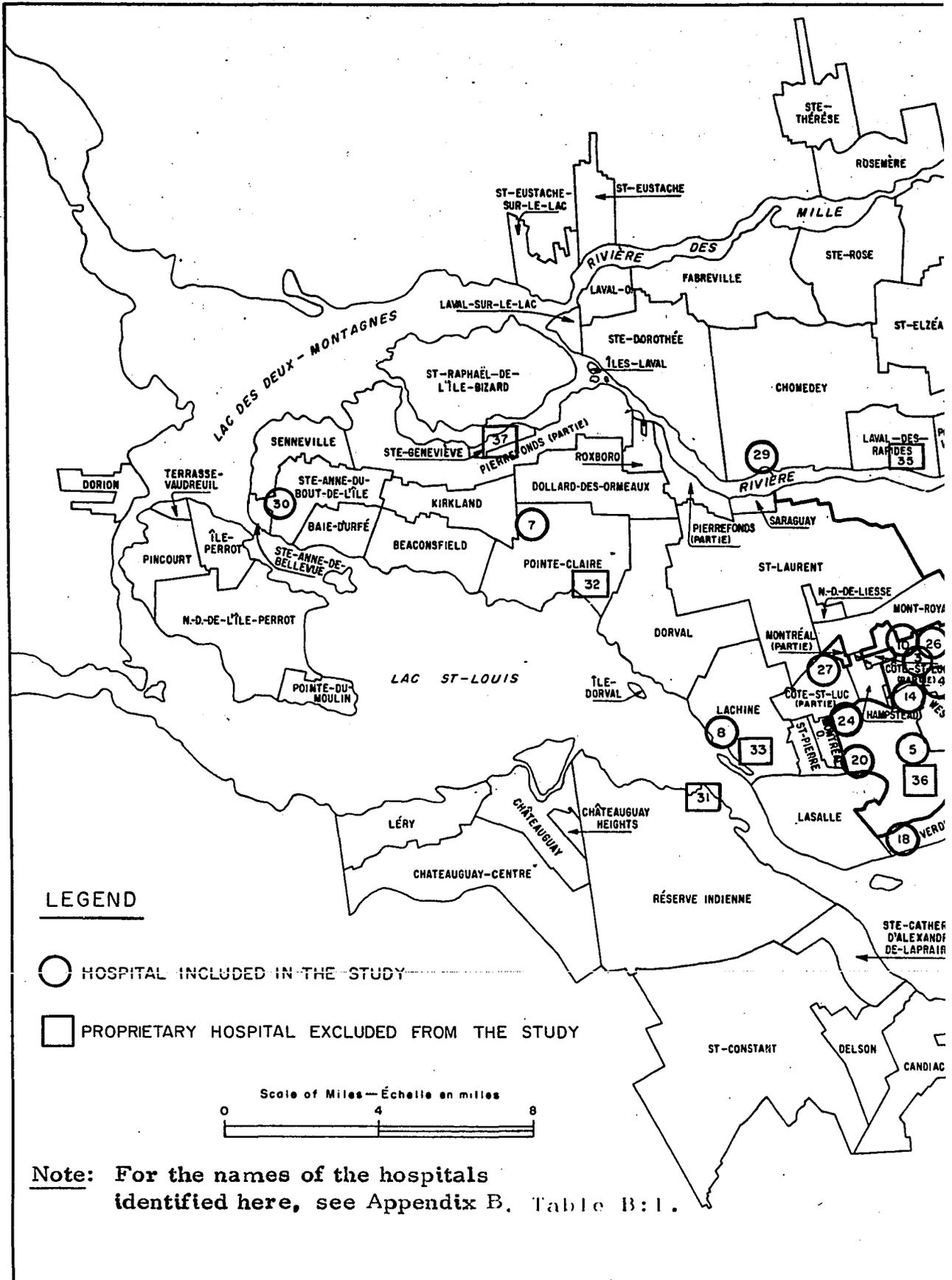


MAP 3

Metropolitan Montreal Showing Location and Type of English Hospitals

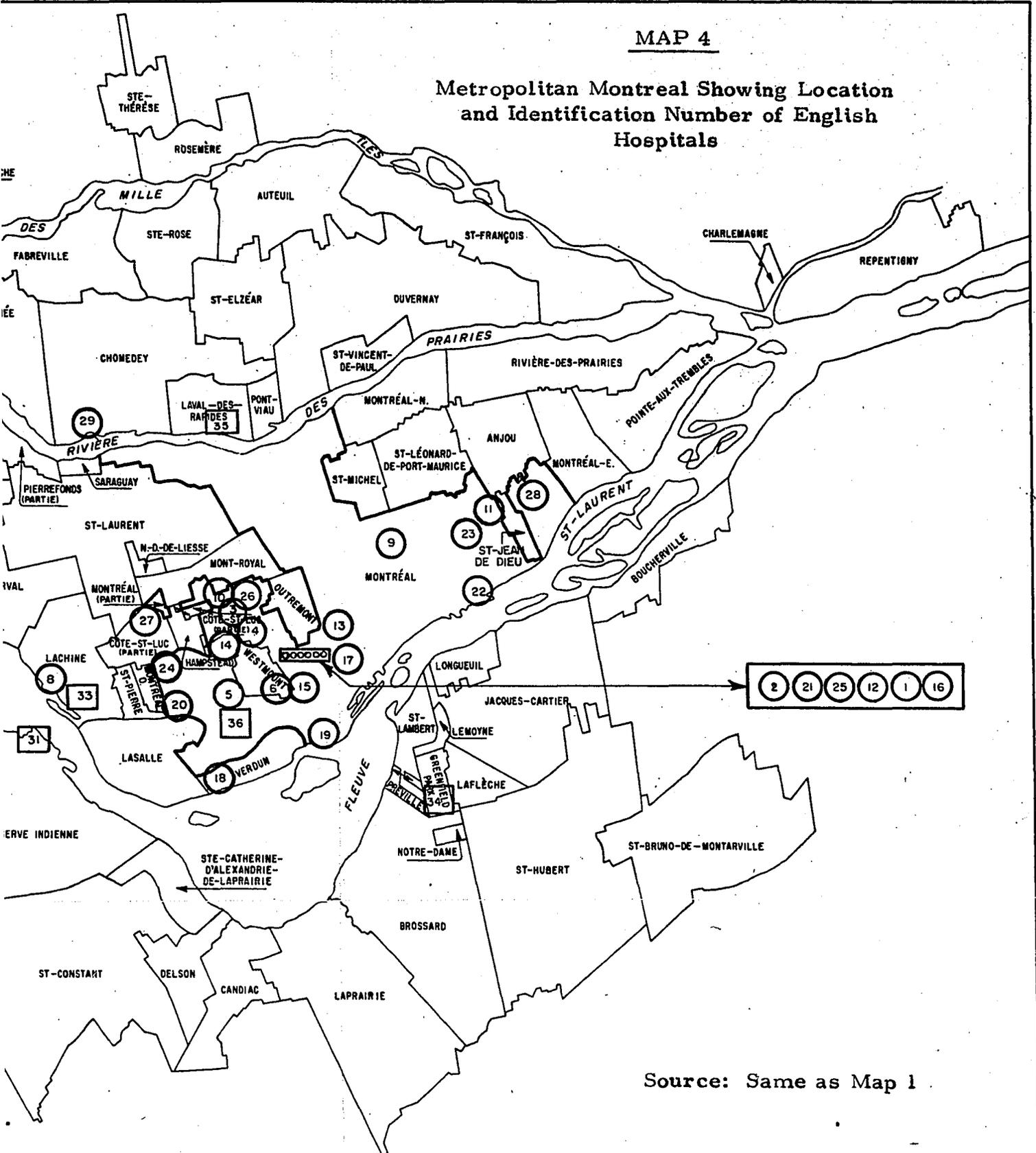


Source: Same as Map 1.

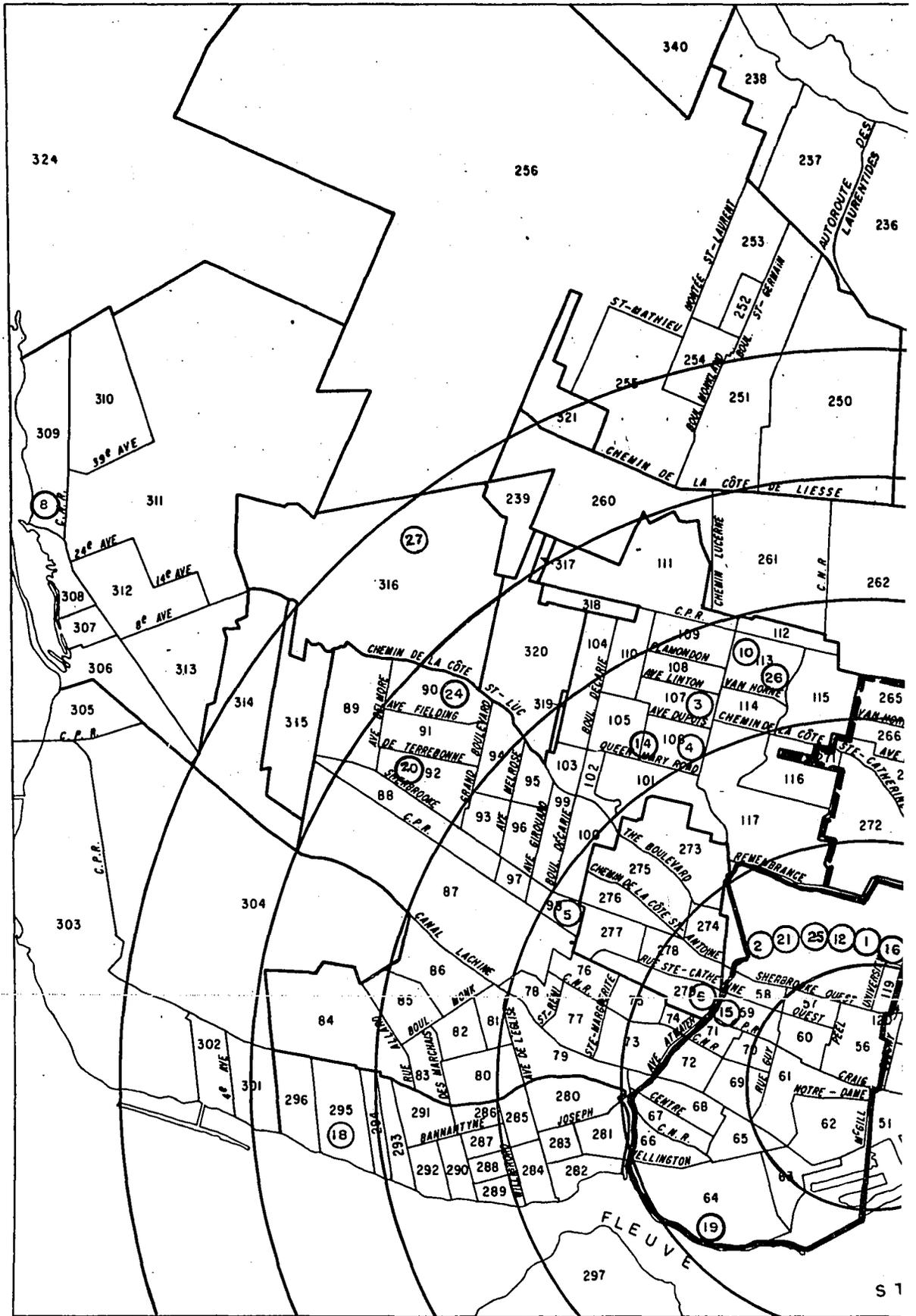


MAP 4

Metropolitan Montreal Showing Location and Identification Number of English Hospitals



Source: Same as Map 1



MAP 5

Part of Metropolitan Montreal, Showing the Downtown Area, the West-Center and East-Center Statistical Areas, and the Location and Identification Number of English Hospitals



Note: For explanations and source of this map, see following page.

Notes to Map 5:

1. The circled numbers on Map 5 refer to English hospitals, which are identified by name and number in Appendix B, Table B:1. The other numbers refer to census tracts.
2. The inner circle represents the "center of the city," the "downtown" area of Montreal as determined by the City of Montreal Planning Department:

Downtown Montreal constitutes the core of the Metropolitan area.

Downtown Montreal is characterized by specific functions: public and private administration, retail trade, financial and banking houses, hotels, cultural and entertainment establishments.

That part of the Downtown Area, where these functions are found concentrated to a certain degree, constitutes the Central Business District. Those portions of the Central Business District in which these functions are highly concentrated form the cores. In Montreal, two distinct cores exist: the Old Core on St. James Street and the Commercial Core in the area surrounding Dominion Square. (See Ville de Montréal, Service d'Urbanisme, "Downtown Montreal," Les Cahiers d'Urbanisme No. 2, April, 1964.)

3. The concentric rings around the Downtown Area are spaced one mile apart. The widest ring, therefore, is 6 miles from the mid point of the Downtown Area. Population density within the city-center and within successive concentric bands around it is shown in Table E:7. The city-center is referred to as "concentric zone 1"; the first band around it as "concentric zone 2" and so on. Only zones 1, and 2 are wholly within the island of Montreal (including Ile Ste. Hélène).

4. The West Center statistical area is shown outlined at center left. The East Center statistical area is shown outlined at center right. They are electoral districts 110 and 9, respectively, of the Quebec College. Map 2 shows them in relation to the other statistical areas of metropolitan Montreal.

Sources: Map: Canada, DBS, 1961 Census of Canada, Population and Housing Characteristics by Census Tracts--Montreal, Bulletin CT--4 (Ottawa: Queen's Printer, 1963), p. 1. Boundaries of Quebec College electoral districts: Quebec, Revised Statutes (1964), c. 249, "An Act Respecting the Medical Profession," sec. 5,3. The city-center: Ville de Montreal, Service d'Urbanisme, La Vague d'Expansion Métropolitaine. Bulletin Technique No. 1 (Montreal: Janvier, 1964), pp. 2-3, and Map 1.

TABLE E:1.--Population of metropolitan Montreal by statistical area and ethnic origin, 1961^a

Statistical Area ^b	British Isles ^c	Jewish ^d	Other non-French ^e	French	Total
Far West	48,384	557	10,891	24,740	84,572
French West	24,361	117	9,173	42,678	76,329
West City	130,664	70,672	57,044	178,985	437,365
West Island ^f	203,409	71,346	77,108	246,403	598,266
West Center	25,731	1,269	13,022	39,443	79,465
East Center	11,314	18,239	37,673	65,301	132,527
North/East Island	75,748	7,848	120,561	731,331	935,488
Montreal Island ^g	316,202	98,702	248,364	1,082,478	1,745,746
Ile Jésus ^h	12,425	3,718	8,863	101,685	126,691
Environs ⁱ	48,998	304	18,453	169,317	237,072
<u>Metropolitan Montreal^j</u>	377,625	102,724	275,680	1,353,480	2,109,509
South-Shore)	37,658	216	15,320	127,701	180,895
West)	2,852	19	805	9,628	13,304
North)	8,187	63	2,136	20,280	30,666
East)	301	6	192	11,708	12,207

Footnotes: see following page

TABLE E:1.--Continued

^aThis table and Table E:2 are meant to indicate as precisely as possible the distribution within metropolitan Montreal of the main ethnic/religious groups and categories. For reasons stated in the other footnotes they lack the ideal precision desirable.

^bThese areas are illustrated in Maps 2 and 5.

^cIncludes English, Irish, Scottish and Welsh.

^dJewish population figures represent Jewish religion, which was a more accurate count, than ethnic origin, of members of the Jewish community in the 1961 Census (communication from Mr. Louis Rosenberg, Research Director, Canadian Jewish Congress). Jewish ethnic origin, in fact, was not given in the census-tract source. In 1961 the Census shows 73,062 persons of Jewish ethnic origin in Montreal, of which 931 were non-Jewish in religion. There were 30,593 persons Jewish in religion who gave something other than Jewish as ethnic origin. Of the latter, 2,077 gave British Isles and 838 gave French as their origin. There is double counting, therefore, by these amounts in the latter categories; and undercounting by 2,915 in the "other non-French" category.

^eThis is a residual category. Its figures differ from comparable Census amounts because they exclude 27,678 persons Jewish in religion who gave something other than British Isles, French, or Jewish as their ethnic origin in the Census. Because of the double counting mentioned in note "d," the category is also undercounted by 2,077 plus 838. If we were to ignore the few (931) Jews who are non-Jewish by religion, take out all ethnic-origin Jews from the appropriate columns and put them in the "Jewish" column, the Montreal Metropolitan row would read: 375,548; 102,724; 278,595; 1,352,642; 2,109,509.

^fThe sum of Far West, French West and West City.

^gThe sum of West Island, West Center, East Center, and North/East Island.

^hIncludes Ile Bizard which has a similar ethnic composition although linked by bridge only to Montreal island. Ile Bizard's population of 1,950 was 88.8% French Canadian in 1961.

ⁱAll those areas within metropolitan Montreal outside of Montreal Island, Ile Jésus and Ile Bizard. See Map 2. Population figures for the different areas comprising "Environs" are given in the table below the metropolitan Montreal row.

^jThe sum of Montreal Island, Ile Jésus and Environs.

TABLE E:1.--Continued

Sources: Ethnic origin by Census tract: Canada, DBS, 1961 Census of Canada, Population and Housing Characteristics by Census Tracts--Montreal, Bulletin CT--4 (Ottawa: Queen's Printer, 1963). Ethnic origin compared to religion: idem., 1961 Census of Canada, Population: Religion by Ethnic Groups, Bulletin 1.3--8 (Ottawa: Queen's Printer, 1964). Census tracts included in the statistical areas: Map 5. Boundaries of Quebec College electoral districts: Quebec, Revised Statutes (1964), c. 249, "An Act Respecting the Medical Profession," sec. 5,3.

TABLE E:2.--Percentage distribution of the population of metropolitan Montreal by ethnic origin and statistical area, 1961

Statistical Area	British Isles		Jewish		Other non-French		French		Total	
	%		%		%		%		%	
Far West	57.2	12.8	0.7	0.5	12.9	4.0	29.3	1.8	100.0	4.0
French West	31.9	6.5	0.2	0.1	12.0	3.3	55.9	3.2	100.0	3.6
West City	29.9	34.6	16.2	68.8	13.0	20.7	40.9	13.2	100.0	20.7
West Island	34.0	53.9	11.9	69.5	12.9	28.0	41.2	18.2	100.0	28.4
West Center	32.4	6.8	1.6	1.2	16.4	4.7	49.6	2.9	100.0	3.8
East Center	8.5	3.0	13.8	17.8	28.4	13.7	49.3	4.8	100.0	6.3
North/East Island	8.1	20.0	0.8	7.6	12.9	43.7	78.2	54.1	100.0	44.3
Montreal Island	18.1	83.7	5.7	96.1	14.2	90.1	62.0	80.0	100.0	82.8
Ile Jésus	9.8	3.3	2.9	3.6	7.0	3.2	80.3	7.5	100.0	6.0
Environs	20.7	13.0	0.1	0.3	7.8	6.7	71.4	12.5	100.0	11.2
<u>Metropolitan Montreal</u>	17.9	100.0	4.9	100.0	13.1	100.0	64.1	100.0	100.0	100.0
South-Shore)	20.8	10.0	0.1	0.2	8.5	5.5	70.6	9.4	100.0	8.6
West)	21.4	0.7	0.1	0.0	6.1	0.3	72.4	0.7	100.0	0.6
North)	26.7	2.2	0.2	0.1	7.0	0.8	66.1	1.5	100.0	1.4
East)	2.5	0.1	0.0	0.0	1.6	0.1	95.9	0.9	100.0	0.6

0.0 = Less than 0.05 per cent, greater than nil.

Footnotes: see following page

TABLE E:2.--Continued

Note:

The footnotes of Table E:1 apply to this table also. For each statistical area the top row percentages read horizontally; for each ethnic-origin category the right-hand column percentages read vertically.

Source: Table E:1.

TABLE E:3.--Population of metropolitan Montreal by official language spoken and statistical area, 1961

Statistical Area ^a	English Only	Neither English nor French	French Speaking		Total
			English and French	Total ^b	
Far West	50,073	305	23,481	34,194	84,572
French West	24,594	583	29,353	51,152	76,329
West City	176,380	7,050	168,356	253,935	437,365
West Island ^c	251,047	7,938	221,190	339,281	598,266
West Center	27,530	1,323	31,618	50,612	79,465
East Center	37,796	11,119	46,223	83,612	132,527
North/East Island	85,183	22,611	359,777	827,694	935,488
Montreal Island ^d	401,556	42,991	658,808	1,301,199	1,745,746
Ile Jésus ^e	15,476	516	41,793	110,699	126,691
Environs ^f	45,228	806	76,002	191,038	237,072
<u>Metropolitan Montreal^g</u>	462,260	44,313	776,603	1,602,936	2,109,509
South-Shore)	35,091	629	58,417	145,175	180,895
West)					
North)					
East)					
Environs ^f	2,763	32	4,653	10,509	13,304
North)	7,210	142	9,851	23,314	30,666
East)	164	3	3,081	12,040	12,207

Footnotes: see following page

TABLE E:3.--Continued

^aSee Maps 2 and 5 and the introductory notes to this appendix for illustration and discussion of these areas.

^bIncludes those who speak both French and English and those who speak French only.

^cThe sum of Far West, French West and West City.

^dThe sum of West Island, West Center, East Center, and North/East Island.

^eIncludes Ile Bizard. See Table E:1 note "g."

^fAll areas within metropolitan Montreal situated outside of Montreal Island, Ile Jésus and Ile Bizard. See Map 2. The figures are distributed among the sub-areas of environs below the metropolitan Montreal row.

^gThe sum of Montreal Island, Ile Jésus and Environs.

Source: Derived from Canada, DBS, 1961 Census of Canada, Population and Housing Characteristics by Census Tracts: Montreal, op. cit.

TABLE E:4.--Percentage distribution of the population of metropolitan Montreal by official language spoken and by statistical area, 1961

Statistical Area	English Only		Neither English nor French		French Speaking		Total			
					English and French	Total				
Far West	59.2	10.8	0.4	0.7	27.8	3.0	40.4	2.1	100.0	4.1
French West	32.2	5.3	0.8	1.3	38.5	3.8	67.0	3.2	100.0	3.6
West City	40.3	38.2	1.6	15.9	38.5	21.7	58.1	15.8	100.0	20.7
West Island	42.0	54.3	1.3	17.9	37.0	28.5	56.7	21.2	100.0	28.4
West Center	34.7	6.0	1.7	3.0	39.8	4.1	63.7	3.2	100.0	3.8
East Center	28.5	8.2	8.4	25.1	34.9	6.0	63.1	5.2	100.0	6.3
North/East Island	9.1	18.4	2.4	51.0	38.5	46.3	88.5	51.6	100.0	44.4
Montreal Island	23.0	86.9	2.5	97.0	37.7	84.8	74.5	81.2	100.0	82.8
Ile Jésus	12.2	3.4	0.4	1.2	33.0	5.4	87.4	6.9	100.0	6.0
Environs	19.1	9.8	0.3	1.8	32.1	9.8	80.6	11.9	100.0	11.2
<u>Metropolitan Montreal</u>	21.9	100.0	2.1	100.0	36.8	100.0	76.0	100.0	100.0	100.0
South-Shore)	19.4	7.6	0.4	1.4	32.3	7.5	80.3	9.1	100.0	8.6
West)	20.8	0.6	0.2	0.1	35.0	0.6	79.0	0.7	100.0	0.6
North)	23.5	1.6	0.5	0.3	32.1	1.3	76.0	1.5	100.0	1.5
East)	1.3	0.0	0.0	0.0	25.2	0.4	98.6	0.8	100.0	0.6

0.0 = Less than 0.05 per cent, greater than nil.

Note: The footnotes of Table E:3 apply to this table also.

Source: Table E:3.

TABLE E:5.--Population of metropolitan Montreal by ethnic origin and by official language spoken, 1961

Ethnic Origin	English Only	Neither English nor French	French Speaking		Total
			French and English	Total ^a	
British Isles	267,091	626	101,767	109,908	377,625
Jewish ^b	44,928	1,419	26,176	26,715	73,062
Other non-French	131,737	40,153	93,731	133,452	305,342
French	18,504	2,115	554,929	1,332,861	1,353,480
Total	462,260	44,313	776,603	1,602,936	2,109,509

^aIncludes those who speak both French and English and those who speak French only.

^bJewish by ethnic origin. There are 29,662 more persons Jewish by religion in metropolitan Montreal. See Table E:1.

Source: Canada, DBS, 1961 Census of Canada, Population: Language by Ethnic Groups. Bulletin 1.3--10 (Ottawa: Queen's Printer, 1963), p. 123--3.

TABLE E:6.--Population of metropolitan Montreal by official language spoken and by ethnic origin, 1961

Ethnic Origin	English Only		Neither English nor French		French Speaking				
					English and French		Total		Total
British Isles	70.7		0.2		26.9		29.1			100.0
		57.8		1.4		13.1		6.9	17.9
Jewish	61.5		1.9		35.8		36.6		100.0
		9.7		3.2		3.4		1.7	3.5
Other non-French	43.1		13.2		30.7		43.7		100.0
		28.5		90.6		12.1		8.3	14.5
French	1.4		0.2		41.0		98.5		100.0
		4.0		4.8		71.5		83.2	64.2
Total	21.9		2.1		36.8		76.0		100.0
		100.0		100.0		100.0		100.0	100.0

Note: The footnotes of Table E:5 apply to this table also.

Source: Table E:5.

TABLE E:7.--Metropolitan Montreal and the Montreal region:^a
population density^b by concentric zone, 1961

Concentric Zone ^c	Montreal Island			South Shore, Ile Jésus and Other Environs ^e	Metropolitan Montreal/ Montreal Region
	Montreal City	Other Areas ^d	Total		
				South Shore	Metropolitan Montreal
1 (city center)	28.6	nil	28.6	nil	28.6
2	52.7	33.3	51.1	nil	51.0
3	57.9	33.2	48.6	9.8	37.8
4	57.3	42.2	54.5	9.4	43.4
5	37.9	23.9	33.0	3.4	15.4
6	16.1	9.8	11.8	7.1	11.6
				Ile Jésus and Environs	Montreal Region
7 plus	23.1	3.8	5.2	0.3	0.5
Total	39.1	6.7	15.6	0.4	1.2

Footnotes: see following page

TABLE E:7.--Continued

^aDefined as the "urban centered" region around metropolitan Montreal, by the City of Montreal Planning Department. Criteria used to establish boundaries include similar geography, established suburban bus service and heavily-used commuter lines, area covered by a one-hour bus trip, wholesale distribution area, and Montreal-centered trading area. Each area included meets at least 75% of the criteria used. See "Le Service d'Urbanisme de la Ville de Montréal, "The Inner Region," Les Cahiers d'Urbanisme No-1 (January, 1963). The Montreal region is illustrated on the following page.

^bPersons per acre of dry land.

^cThe concentric zones correspond to the area within concentric bands shown on Map 5. The first "concentric zone" is the inner circle on Map 5, corresponding to the "city-center" as established by the City of Montreal Planning Department. Apart from zone 1, figures relate to the area within the concentric band, not within the entire circle. Only six concentric zones are shown on Map 5, extending six miles from the middle of the city-center. Zones 1 to 6 are entirely within Montreal Island or Montreal Island and the South Shore. Other zones extend beyond these areas. The maximum width of the Montreal region is 46 miles from mid city-center. However, the widest complete concentric zone is 25 miles; wider zones extend partly beyond the region.

^dOrganized areas on the island of Montreal other than the City of Montreal, Westmount and Outremont for example.

^eThese areas correspond to the areas shown on Map 2.

Source: Ville de Montréal, Service d'Urbanisme, La Vague d'Expansion Métropolitaine, Bulletin Technique No. 1 (Montréal: Janvier, 1964), Tables 2, 3, and 8.

APPENDIX F

MISCELLANEOUS

APPENDIX F

Item 1

COMPARISON OF ENGLISH-MONTREAL PHYSICIANS, AND
ATTENDING PHYSICIANS AT ENGLISH-
MONTREAL HOSPITALS

Because of the way we define our physician population we are faced with the fact of physicians listed as medical staff at English-Montreal hospitals but who are not considered English-Montreal physicians in this study because they are, (1) retired, (2) residents/fellows, (3) their main office is outside metropolitan Montreal, or (4) they are French-Montreal physicians (they have French preferred language and no attending affiliation at an English-Montreal hospital).

The table below shows the physicians--by main type of hospital affiliation--who were included on English-hospital lists but were excluded from the population of this study. The table does not include them, and we did not computer-check how many physicians with French preferred language, who are consulting or partial affiliation physicians at English-Montreal hospitals, were excluded because they have no attending affiliation at these hospitals.

Type of Hospital Affiliation ^a	Reason not in the Study			
	Retired	Out of Town ^b	Other ^c	Total
Attending	..	12	25	37
Consulting	26	15	4	45
Partial Affiliation	1	6	2	9
Total	27	33	31	91

^aThese affiliation types and the medical-staff terms that they encompass, are discussed in Appendix A Hospitals section.

^bMain office not in metropolitan Montreal.

^cFor consulting and partial affiliation, "other" means physician could not be traced, is not licensed because engaged in a non-medical or non-treatment activity, or is a resident/fellow.

The reasons given for the absence of physicians from the study were determined by examining the following documents: Bottin Médicale (the official list of physicians and surgeons of the Province of Quebec); the Canadian Medical Directory 1966 and 1967 (Toronto: Seccombe House, annual); the Quebec College lists of residents and fellows at English-Montreal hospitals; and the yellow and white pages of the Montreal telephone directory. Their "absence" was observed because, (1) they did not appear on a Quebec College list that included all metropolitan Montreal physicians as well as some physicians in other areas, or (2) a computer check at the time of data tabulation showed them to be excluded from the population for one of three reasons.

Additional data on the excluded attending physicians are given in the table below.

Table showing, for certain hospitals,^a total number of attending physicians on hospital list, number of such physicians excluded from the population studied and reason for exclusion, and number of attending physicians included in the study

Category and Hospital	Total Phys. Listed	Excluded Physicians			Physicians in the Study
		Out of Town	Out of town, Retired, or Resident/Fellow ^b	Other	
General Hos.:					
G1: Royal Vic.	249	2	...	2	245
Mtl. Gen.	157	1	1	...	155
G2: Jewish Gen.	198	1	3	...	194
G3: St. Mary's	84	2	...	...	82
G4: Queen Eliz.	75	...	2	1	72
G5: Lakeshore Gen.	90	4	...	...	86
G6: Bellechasse Doctors	60	1	...	...	59
	33	1	1	...	31
Special Hos.:					
S1: Childrens	159	...	2	2	155
Neuro	22	...	...	3	19
S2: Royal Edward	27	...	1	1	25
Douglas	25	...	1	...	24
S3: Catherine B.	48	...	1	1	46
Shriners	11	...	1	...	10
S5: Maimonides	32	...	...	2	30
S6: Ste. Anne's	15	...	...	1	14
Total	1285	12	13	13	1247

^a"Certain hospitals": for the other hospitals, all listed attending physicians are included in the study (see Appendix B Tables B:7 and B:16).

^bExcluded because of a computer check at time of data tabulation.

The "Other" excluded physicians really amount to 12, since one has duplicate affiliation. Two of these 12 are residents/fellows. Of the other ten, none are listed in the Bottin Médicale for 1967; five are not listed in the Canadian Medical Directory of 1966, 1967 or 1968; and two of the latter are not shown as "doctor" in the phone books. Of the remaining five, two possibly could be full-time medical teachers and researchers and thus may not need a licence. The other three appear to be in practice, although apparently unlicensed.

We should note that there may be duplication among staff categories in the first table. For this reason there probably are fewer than 91 listed physicians excluded from the study, although 91 listed positions are excluded. Similarly, in the second table, because there is duplication among hospitals, we are really considering positions not physicians. As noted earlier (see Appendix C Table C:1), while there are 1,447 attending positions, there are only 1,008 attending physicians in the study.

There may be French Canadians among the excluded consulting and partial affiliation physicians. Some of the out-of-town attending physicians are abroad and some are in the United States and Ontario. Others are in areas close to but outside of metropolitan Montreal. Perhaps we could assume that the latter, being relatively distant from Montreal hospitals, would not play a major part in their affairs. Although this might not be true of the three Hudson Heights and one Vaudreuil physician excluded from the Lakeshore General in this study.

APPENDIX F Item 2

LE COLLÈGE DES MÉDECINS ET CHIRURGIENS DE LA PROVINCE DE QUÉBEC
THE COLLEGE OF PHYSICIANS AND SURGEONS OF THE PROVINCE OF QUEBEC

1896 OUEST, BOUL. DORCHESTER — 1896 DORCHESTER BLVD. WEST
MONTRÉAL 25, P.Q.

R A P P E L
R E M I N D E R

AVIS DE COTISATION
1966/67
NOTICE OF ANNUAL FEE

A) COTISATION — FEE INDIQUEZ LE CAS QUI S'APPLIQUE — INDICATE WHERE APPLICABLE

- 1) COTISATION ANNUELLE RÉGULIÈRE — REGULAR ANNUAL FEE \$75.00
- 2) COTISATION RÉDUITE S'APPLIQUANT AUX MÉDECINS: — REDUCED FEE APPLICABLE TO DOCTORS
- a) ÂGÉS DE 70 ANS OU PLUS — 70 YEARS OLD OR OVER \$20.00
- b) RÉSIDENTS, MONITEURS — RESIDENTS, FELLOWS \$10.00

VOIR QUESTION NO 4 — SEE QUESTION NO. 4

B) CHANGEMENT D'ADRESSE — CHANGE OF ADDRESS

NOUVELLE ADRESSE — NEW ADDRESS

VALIDE LE
EFFECTIVE _____

C) QUESTIONNAIRE

1) ACTIVITÉS PROFESSIONNELLES — PROFESSIONAL ACTIVITIES

[SI VOUS INDIQUEZ PLUS D'UNE ACTIVITÉ, VEUILLEZ LES NUMÉROTÉ PAR ORDRE D'IMPORTANCE (EN TERMES D'HEURES) DANS LES CASES À GAUCHE.]

[IF YOU CHECK MORE THAN ONE ACTIVITY PLEASE NUMBER THEM ACCORDING TO THEIR IMPORTANCE (IN TERMS OF HOURS OF WORK) IN THE BOXES ON THE LEFT.]

- | | |
|---|--|
| <input type="checkbox"/> 1. PRATIQUE GÉNÉRALE
GENERAL PRACTICE | <input type="checkbox"/> 9. ENSEIGNEMENT DANS LES DISCIPLINES FONDAMENTALES
TEACHING IN BASIC SCIENCES |
| <input type="checkbox"/> 2. RÉSIDENT OU MONITEUR
RESIDENT OR FELLOW | <input type="checkbox"/> 10. ENSEIGNEMENT DANS LES DISCIPLINES CLINIQUES
TEACHING IN CLINICAL DISCIPLINES |
| <input type="checkbox"/> 3. ADMINISTRATION HOSPITALIÈRE
HOSPITAL ADMINISTRATION | <input type="checkbox"/> 11. RECHERCHE EN MILIEU HOSPITALIER
RESEARCH IN A HOSPITAL |
| <input type="checkbox"/> 4. AUTRE GENRE D'ADMINISTRATION
OTHER TYPE OF ADMINISTRATION | <input type="checkbox"/> 12. AUTRE RECHERCHE
OTHER RESEARCH |
| <input type="checkbox"/> 5. MÉDECINE DE LABORATOIRE (PATHOLOGIE, ETC.)
LABORATORY MEDICINE (PATHOLOGY, ETC.) | <input type="checkbox"/> 13. RETRAITÉ
RETIRED |
| <input type="checkbox"/> 6. MÉDECINE PRÉVENTIVE
PREVENTIVE MEDICINE | <input type="checkbox"/> 14. SEMI-RETRAITÉ
SEMI-RETIRED |
| <input type="checkbox"/> 7. MÉDECINE INDUSTRIELLE
INDUSTRIAL MEDICINE | <input type="checkbox"/> 15. EXAMINATEUR POUR CIE D'ASSURANCE
EXAMINER FOR INSURANCE COMPANY |
| <input type="checkbox"/> 8. AUTRE GENRE DE PRATIQUE SPÉCIALISÉE
OTHER SPECIALTY PRACTICE | <input type="checkbox"/> 16. AUTRE
OTHER |

(SPÉCIFIEZ — SPECIFY)

SUITE AU VERSO — CONTINUED ON REVERSE SIDE

2) SOURCES DE REVENU PROFESSIONNEL — SOURCES OF PROFESSIONAL INCOME

[SI VOUS INDIQUEZ PLUS D'UNE SOURCE, VEUILLEZ LES NUMÉROTÉ PAR ORDRE D'IMPORTANCE, (EN TERMES D'HEURES PAR SEMAINE) DANS LES CASES À GAUCHE.]

[IF YOU CHECK MORE THAN ONE SOURCE, PLEASE NUMBER THEM ACCORDING TO THEIR IMPORTANCE, (IN TERMS OF HOURS OF WORK) IN THE BOXES ON THE LEFT.]

- | | | | |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | 1. À VOTRE COMPTE
SELF EMPLOYED | <input type="checkbox"/> | 6. UNIVERSITÉ
UNIVERSITY |
| <input type="checkbox"/> | 2. HÔPITAL
HOSPITAL | <input type="checkbox"/> | 7. COMPAGNIE D'ASSURANCE
INSURANCE COMPANY |
| <input type="checkbox"/> | 3. MINISTÈRES OU AGENCES DU GOUVERNEMENT PROVINCIAL
DEPARTMENTS OR AGENCIES OF THE PROVINCIAL GOVERNMENT
(SAUF PRESTATIONS DE LA COMMISSION DES ACCIDENTS DE TRAVAIL)
(EXCEPT FEES FROM THE WORKMEN'S COMPENSATION COMMISSION) | <input type="checkbox"/> | 8. COMPAGNIE PHARMACEUTIQUE
PHARMACEUTICAL COMPANY |
| <input type="checkbox"/> | 4. GOUVERNEMENT FÉDÉRAL
FEDERAL GOVERNMENT | <input type="checkbox"/> | 9. AUTRE INDUSTRIE
OTHER INDUSTRY |
| <input type="checkbox"/> | 5. MUNICIPALITÉ
MUNICIPALITY | <input type="checkbox"/> | 10. AUTRE
OTHER |

SPÉCIFIEZ — SPECIFY

3) MODE DE RÉMUNÉRATION — FORM OF REMUNERATION

- | | | | | | |
|--------------------------|--|--------------------------|--------------------------------|--------------------------|--|
| <input type="checkbox"/> | 1. RÉMUNÉRATION À L'ACTE SEULEMENT
FEE FOR SERVICE ONLY | <input type="checkbox"/> | 2. SALAIRE SEUL
SALARY ONLY | <input type="checkbox"/> | 3. SALAIRE & RÉMUNÉRATION À L'ACTE
SALARY AND FEE FOR SERVICE |
|--------------------------|--|--------------------------|--------------------------------|--------------------------|--|

4) SI VOUS ÊTES RÉSIDENT OU MONITEUR — IF YOU ARE RESIDENT OR FELLOW

a) EN VUE DE QUELLE SPÉCIALITÉ?
WITH WHICH SPECIALTY IN VIEW? _____

b) EN QUELLE ANNÉE COMPTÉZ-VOUS TERMINER VOTRE RÉSIDENCE?
IN WHICH YEAR DO YOU EXPECT TO COMPLETE YOUR RESIDENCY? _____

c) NOMMEZ LES HÔPITAUX OÙ VOUS TRAVAILLerez ENTRE LE 1er JUILLET 1966 ET LE 1er JUILLET 1967.
NAME THE HOSPITALS WHERE YOU WILL BE WORKING BETWEEN JULY 1st, 1966 AND JULY 1st, 1967.

1 _____

2 _____

3 _____

APPENDIX F

Item 3

DATA COLLECTED ON EACH QUEBEC PHYSICIAN BY THE COLLEGE OF
PHYSICIANS AND SURGEONS OF THE PROVINCE OF QUEBEC, AND
RETAINED ON MAGNETIC TAPE

1. Code number showing the year in which the physician was first licensed to practise in Quebec
2. Address of main office
3. Municipality where main office located
4. County where main office located
5. Type of municipality where main office located:
metropolitan area, or other city,
town or village by size-group
6. Provincial economic-region where main office located
7. Quebec College electoral district where main office located: five such districts on the island of Montreal
8. Year of birth
9. Sex
10. Religion (data incomplete)
11. Country of birth
12. Year of arrival in Canada, if foreign born
13. Year of Canadian citizenship, if immigrant
14. Ethnic origin
15. Language preferred for correspondence from Quebec College: French or English
16. Other languages spoken
17. University or country where M.D. obtained
18. Year M.D. obtained
19. Type of licence obtained: regular, Licence of the Medical Council of Canada, British licence, temporary licence, special petition
20. Specialties in which certificated by Quebec College and years certifications obtained: up to a total of three certifications
21. Specialties in which certificated by Royal College of Physicians and Surgeons of Canada: up to a total of three certifications
22. Whether a fellowship is held from the Royal College of Physicians and Surgeons of Canada

- *23. Professional activities: as of mid 1966
- *24. Sources of professional income: mid 1966
- *25. Mode of professional remuneration: mid 1966
- 26. Whether or not the questionnaire (Appendix F Item 2) was answered.

*Although the Quebec College's magnetic tape was updated to April 1967 for each of the other items, these three items might have changed for particular physicians between mid 1966 when the College's questionnaire (Appendix F Item 2) was administered, and April 1967 to which period the hospital-affiliation data apply. See the questionnaire for additional detail on these items.

Note:

The Quebec College collected some additional data on residents and fellows that are not listed here.

APPENDIX F

Item 4

INFORMATION REQUESTED FROM MONTREAL HOSPITALS

1. Would you please supply the following information on the medical staff of your hospital, as of April 1967:

- A. A list of the Consulting Staff.
- B. A list of the Attending Staff.
- C. A list of the "visiting" and/or "courtesy" staff (or whichever term you may use for any physicians who have some admission and treatment privileges at your hospital but who are not regular members of the hospital medical staff).
- D. A list of any physicians who are not shown on one of the above lists and who are engaged in Research, Teaching, or Administration at the hospital.

Please Note: In listing the names of physicians affiliated with the hospital, would you please show the physician's first name and surname in full as well as the other-name initials he may use.

- E. A list of the Honorary Staff is not required.

2. Would you indicate to what extent your hospital is "open" or "closed", that is to what extent physicians who are not included in the lists named in question 1 have the privilege to admit and treat their private patients at your hospital.

3. Would you please include with your response the most recently published copy of the Annual Report of your hospital.

Please Note:

For your convenience a stamped self-addressed envelope is enclosed.

Thank you for your cooperation.

APPENDIX F

Item 5

Interviews

1. Hospitals Represented by Physicians Interviewed:
General Hospitals: Royal Victoria, Montreal General, Jewish General, St. Mary's, Lakeshore General, Lachine General, Doctors Hospital, Queen Mary Veterans.
Special Hospitals: Montreal Neurological, Royal Edward Chest, Grace Dart, Jewish Hospital of Hope, Ste. Anne's Veterans.
2. Hospitals Represented by Lay Administrators Interviewed:
General Hospitals: Reddy Memorial, Bellechasse, Kateri Memorial.
3. Other Medical Organizations Represented by Persons Interviewed: McGill University, Faculty of Medicine; Quebec Hospital Association; Association of Private Hospitals of Quebec; Quebec Department of Health.
4. Medical Specialties and Major Areas of Activity Represented by Physicians Interviewed:
Internal medicine, neurology, cardiology, psychiatry, and gerontology.
General practice, specialty practice, hospital administration, residency, medical administration (medical director), medical school administration, government health administration.
5. Physicians interviewed had been in practice for periods ranging from 4 to 35 years.

APPENDIX G

PHYSICIANS OF ENGLISH MONTREAL:
SOCIAL CHARACTERISTICS

Note: A nil entry in the tables is indicated by "0.00."

APPENDIX G

PHYSICIANS OF ENGLISH-MONTREAL: SOCIAL CHARACTERISTICS

This appendix presents data on social characteristics of English-Montreal physicians by certain main types of hospital affiliation.¹ These are presented for the reader with a special interest in medical sociology or in details of the medical profession in English Montreal. They were tabulated because it is the first time such extensive data have become available on the total physician population of a Canadian community.²

We intend in the next pages to comment briefly on some of the more important comparisons that can be made with the data in Tables G:1 to G:8. We have data on two kinds of physician characteristics. First are what we may call "access" characteristics,³ since they are factors that could presumably

¹For the sake of simplicity we use fewer hospital categories in this appendix than we did in chapters III, IV and V. Since we saw, in chapter III, that ownership and teaching-hospital standing were the most important hospital characteristics in ranking the prestige of hospitals, we use these factors to distinguish the English Montreal hospitals in the present appendix. Because of their special situation as minority-group hospitals within the English-speaking medical system of Montreal, we show figures for the Jewish General and St. Mary's hospitals separately, and also included, as appropriate, within the categories "partial-teaching only" and "duplicates." The categories of physicians without attending affiliation correspond to those used in chapters III and V. The number of physicians in categories "chronic/convalescent only," "proprietary only," and "public hospitals" are the same as in chapters IV and V.

²Saskatchewan's province-wide medical insurance plan generates very detailed statistics on patterns of practice among different categories of physicians. These data, however, for the most part have not yet been published.

³Age, sex, number of years since first licensed to practice medicine in Quebec ("recent arrival" or "long establishment"), number of years since graduation from medical school ("long or short experience"), and French as a preferred language ("French speaking").

influence a physician's access to the more or less prestigious hospital facilities and practice settings. Secondly there are "career" characteristics¹ that provide additional detail about the content of medical careers in different hospital-affiliation settings. The latter characteristics are given little comment here since they tend to support the prestige-ranking of hospital types that we attempted in Chapter III.

Social Characteristics

We assume that youth, female sex, short experience, recent arrival, and being French-speaking (in an English milieu) would probably be disadvantageous to a physician becoming part of the medical staff in a more prestigious hospital setting. Our emphasis here, as throughout the study, is not upon the physician's "life chances" of getting into a particular setting, but rather upon his chances of having numerical weight within a particular setting equal to his weight in the total medical system. We will examine selected physician/hospital categories in the following sections.

Major Teaching and Non-teaching Hospitals²

Compared to the partial-teaching hospital physicians and all attending physicians we find more younger physicians, more women, more recent arrivals at these hospitals. Indeed there are more recent arrivals at the major-teaching than at the non-teaching hospitals. This suggests that these characteristics are drawbacks for some physicians but not for others. Perhaps there are some other factors operative here--possibly high marks in medical school,³ or outstanding performance during residency⁴--that override the disadvantageous characteristics for high performers and reinforce them for low performers. Certainly women, short-experienced, and French physicians are more predominant in the less prestigious non-teaching hospitals

¹Specialty of physicians certificated by the Quebec College; main professional activity; professional activity that is either main, second or third; main income source; income source that is either main, second or third; and form of remuneration.

²In most of these categories the word "only" is understood though not stated. See explanation of the categories in Table G:1.

³As suggested by a Royal Victoria physician interviewed. Interview 1.

⁴Professor Solomon's data showing the influence of location of internship/residency upon the class of hospital affiliation supports this suggestion. David N. Solomon, "Career Contingencies of Chicago Physicians," op. cit., pp. 49 to 70.

than in the elite major-teaching. We note the large number of recently arrived (in Quebec) physicians at the major-teaching hospitals, which lends support to our conclusion that elite hospitals, with their emphasis upon high standards of qualification and performance, select physicians judged up to standard from a wide variety of social backgrounds.¹ The less prestigious non-teaching hospitals select physicians also with a wide variety of social backgrounds--more so than the major teaching in fact--but here presumably there are not the same attractive medical achievements to counteract the disadvantageous social characteristics. Both are "cosmopolitan"² operations, the former for physicians with outstanding qualifications, the latter for the less outstanding.

Partial Teaching Hospitals

Compared to the major-teaching the partial-teaching hospital physicians are older, are more often men, are longer established and experienced, and are more seldom French. This suggests a more "local" operation at these hospitals, with control largely in the hands of older, long established and local (as we saw in Chapter V) physicians. For these somewhat restrictive characteristics either the Jewish General or the St. Mary's hospital physicians may be observed to surpass the average of their class.³ Perhaps all the partial teaching hospitals are more defensive in their administrative operations since they presumably aspire to teaching-hospital status but do not have this full acceptance. Perhaps, also, the minority-group hospitals of this type are a little more defensive because they aim to assist minority-group physicians to gain recognition within the larger system of medicine.

¹The relative ethnic homogeneity in elite hospitals (G1 and S1), however, has already been noted in chapter III.

²The terms "cosmopolitans" and "locals" developed by Robert K. Merton and Alvin W. Gouldner in regard to social roles and careers, may also be applied to formal organizations in which these career types tend to predominate. See Alvin W. Gouldner, "Cosmopolitans and Locals: Toward an Analysis of Latent Social Roles--I and II," Administrative Science Quarterly, Vol. 2 (December, 1957 and March, 1958), pp. 281 to 306 and 444 to 480.

³Of Jewish General physicians 76.29% are included in partial-teaching only and 23.71% in duplicates. Of St. Mary's physicians, 60.98% are included in partial-teaching only, and 39.02% in duplicates.

Duplicates

This category being made up of physicians who have¹ affiliation at hospitals of the previous three categories, its physicians fall arithmetically between the highest and the lowest, and not much can be adduced from the figures. We do not know, for instance, whether this multi-category affiliation signifies an advantageous career. We should look at career characteristics to shed some light on this. Virtually all the physicians are specialists we may note, and paediatricians and obstetrician/gynecologists are heavily represented. Surgeons are underrepresented. Virtually all have patient treatment as one of their activities and self-employment as an income source. Few are on salary only, although a large per cent receive a salary in addition to fee-for-service payments.

Thus patient treatment appears to be the main orientation of these physicians and duplicate-category affiliation probably results from the demands of their patient-centered practice. It would be very important for a paediatrician, for example, to have affiliation at the Children's as well as at his partial-teaching or non-teaching hospital.

Chronic Hospitals

We are dealing here with a handful of physicians whose only hospital affiliation is with a chronic hospital. They are mostly older, of long Quebec residence, and long experience, with a large number French-speaking. Surgeons are heavily represented among the specialists. This somewhat lesser prestige practice-setting appears to be occupied by physicians retired, because of age or other reasons, from a heavy involvement in private practice.

Proprietary Hospitals

As we saw in Chapter III, the proprietary-hospital setting appears as the less prestigious among the general hospitals, and this presumably affects more those physicians whose only affiliation is with a hospital of this category.

¹These 185 physicians are affiliated at the hospital categories in this manner. Major Teaching: G1, 47.03%; S1, 45.41%. Partial Teaching: G2, 24.86%; G3, 17.30%; G4, 29.73%; S2, 8.65%. Non-teaching: G5, 16.22%; S3, 25.41%. It is evident, therefore, that a plurality of physicians is affiliated with the major-teaching hospitals. An examination of Appendix C Tables C:6 and C:7 shows that the multiple-category affiliation is mostly between partial teaching and major teaching, or between non-teaching and major teaching, and relatively little between partial-teaching and non-teaching.

Many of these physicians are young, are recent graduates and nearly two-thirds are French-speaking; although only an average number are recent arrivals. Again we should look at these physicians' career characteristics. While only 22 of 83 (26.5%) are certificated, surgeons are very heavily represented among the specialists, and obstetricians/gynecologists are well represented. Virtually all physicians have patient-treatment as their main activity, self-employment as their main income source, and fee-for-service as their only form of income. Proprietary hospitals are thus locales predominantly staffed by physicians whose main professional interest is patient treatment, and who do not have other ties with the profession through research or teaching. The high number of surgeons among specialists, on the one hand, and of general practitioners among all physicians, on the other, suggest these hospitals function as referral systems for "individualistic" rather than "colleague" oriented physicians.¹ The relative absence of women in this setting would tend to confirm its competitive nature.

Proprietary hospitals thus appear to be referral systems whereby general practitioners and French-speaking physicians who presumably do not have access to beds elsewhere are provided with them, while the specialists acquire referred patients. One may wonder at the significance of a situation where hospitals owned by Jewish Montrealers,² provide access to beds to many French-speaking physicians and provide services

¹These types developed by Oswald Hall ("Types of Medical Careers," *AJS*, LV (November, 1949), 243-53) were confirmed by David N. Solomon's interviews with physicians in different class-categories of Chicago hospitals. Solomon analysed the situation among physicians in elite hospitals as "fraternal, and the bonds are those of collegueship." "They are bound together by institutional loyalty and the obligations of collegueship, which apply to all staff members according to the status of each." Among the category of heterogeneous hospitals (many of which were proprietary) he found "the situation is exploitative, and the bonds are those of mutual interest, defined largely in pecuniary terms, i.e., referrals or some other form of quid pro quo." Speaking of the latter hospitals he wrote, "there appears to be an inner core of specialists, who control important . . . hospital positions, sometimes simply because they actually own the hospitals." This sounds very much like the situation as it appears at the English-Montreal proprietary hospitals from our statistical data. See D. N. Solomon, *op. cit.*, pp. 135-54.

²Ownership data from interviews 18, 22, 23 and 24. Most Jewish Montrealers are members of the English-speaking community. See Appendix E Tables E:5 and E:6.

to many French-Canadian patients.¹ Why would French patients choose these English-owned hospitals? Why would French physicians affiliate themselves with these hospitals? Is the shortage of hospital beds more pronounced in the French community; or is the process of gaining admittance to medical staffs more difficult for physicians in the French-speaking medical system?² These are interesting though unanswered questions about comparative differences between the French and English-speaking medical systems.

In any case the proprietary hospitals function on the margin of both language communities, perhaps introducing French patients and physicians to English medical attitudes,³ and providing access to beds for French physicians who are outside of their own system of hospital practice.

Public Hospitals

These physicians, like the chronic hospital category though not to the same degree, are also older, more experienced and longer established. Many are French speaking. Since institutional practice is not highly prestigious this would be expected. Most are employed by the government or by the hospital on salary.

Unaffiliated

Compared to attending physicians, the characteristics that could adversely affect hospital affiliation are common among unaffiliated physicians. They are somewhat younger; many are women and are recent arrivals; somewhat more are recent graduates. None are French-speaking--by definition.

¹The predominance of French-speaking patients at 4 of the 5 proprietary hospitals from interviews 18 and 23, and phone conversations with hospital officials at two of the hospitals.

²The categories of staff affiliation seem to be more numerous at some French hospitals, perhaps making the process of full membership longer. This was suggested in one of the interviews, no. 1. At French hospitals we encounter categories such as régulier (and its subdivisions), associé, visiteur, and éligible.

³Some proprietary-hospital physicians emphasized that these hospitals were oriented to medicine as taught at McGill rather than at the French universities, and that they were within the English-speaking orbit of medicine. A very useful description of how French-Canadian attitudes towards medicine differed, during the recent past anyway, from the English is Agnes M. Ferencz, "The Impact of Urbanization on French Canadian Medical Attitudes," (unpublished Master's thesis, McGill University, 1945).

The many older, long established and long experienced among them suggest that, if attending affiliation is not achieved after a number of years, it will never be achieved, perhaps due to the particular orientation of the physician's career.

We should note, however, that the non-clinical are highly represented among the specialists and psychiatrists are numerous. Perhaps hospital affiliation is not necessary for these physicians. A high proportion are engaged in industrial medicine, and in laboratory or preventive medicine, and "other" medical activities, which also might not require hospital affiliation. However, 78% are engaged to some degree (72% as their main activity) in patient treatment (compared to 94% for attending physicians) and presumably would require hospital affiliation for this part of their career.

We may note that, while a high proportion have two professional activities, few have more than one income source--and many are on salary only--suggesting a more restricted career content for the unaffiliated.

Partial Affiliation Only

This is a problematical category since we do not know why these physicians only have partial affiliation. The kinds of things they are doing suggest that they perhaps do not wish closer involvement in a hospital's affairs, and that they are self-selected out of the attending-staff category. Psychiatrists are numerous among their few specialists, but so are medical specialties. Some have administration or industrial medicine as their main activity, and a considerable number are engaged to some degree in laboratory or preventive medicine or "other" activities. However, their involvement in patient treatment (86.6% to some degree) suggests that attending-staff affiliation would be a normal part of their medical practice.

Forty-nine (73% of total) have "out-patient staff" as their partial affiliation. This is usually a period of trial before admittance to the attending staff. Perhaps this is why partial-affiliation-only physicians do not exhibit negative access characteristics to the same degree as the completely unaffiliated.

Consulting Only

These physicians,¹ by definition, are virtually all older (72% 65 and over; 93% 55 and over). Since the mandatory retirement age is between 62 and 65 in most hospitals; and since most retired attending physicians are appointed to the consulting (or honorary attending) staff, this is not surprising. The figures are instructive, however, of what an older group of physicians--long established in Quebec and of long experience; mostly ex-attending staff--are actually doing in the years prior to their full retirement from practice. Virtually all are still in patient treatment and self-employment, though fewer than attending physicians are engaged in research or teaching. Many, however, have activities in the category covering laboratory and preventive medicine, and "other." Nearly three-quarters receive income only in fee-for-service payments. Patient treatment, then, becomes the main focus for the older pre-retirement physician.

Jewish General and St. Mary's

We can compare these two minority-group hospital physicians with the categories partial-teaching only and duplicates. We may note that most of their duplicates are at the major-teaching rather than the non-teaching voluntary hospitals.² We have already commented upon the access characteristics of these physicians. Here we may note that paediatricians tend to be numerous at both hospitals--especially at the Jewish General--while surgeons are numerous at St. Mary's. Non-clinical specialists are few.

Nearly all have patient treatment as their main activity, while few are in administration, industrial medicine, or laboratory and preventive medicine and "other." They have a higher proportion with self-employment as their main income source and more in self employment to some degree. Finally a greater number of Jewish General physicians earn fees only; and fewer of physicians at both hospitals have income in the form of salary only.

¹We should note that these are not all the hospital consultants. Consulting-staff affiliation is also held by 230 physicians who are attending-staff at an English Montreal hospital. Of these, 137 are attending at the Royal Victoria or the Montreal General. Nearly 30 others are attending at the Children's or the Neuro.

²See Appendix C Tables C:6 and C:7.

TABLE G:1.--Percentage distribution of physicians by type of hospital affiliation and by age

Type of Hospital Affiliation	Age: Years						N (100%)
	Under 25	Under 35	Under 45	45 to 54	55 to 64	65 and over	
	%	%	%	%	%	%	
ATTENDING PHYSICIANS: ^a							
Voluntary General and Acute-Special Hospitals: ^b							
Major Teaching ^c)	0.30	10.54	52.71	30.42	16.27	0.60	332
Partial Tchg. ^d)	0.00	8.74	44.75	28.67	24.83	1.75	286
Non-teaching ^e)	0.00	10.13	55.70	35.44	8.86	0.00	79
Duplicates ^f)	0.00	6.49	51.90	33.51	14.59	0.00	185
Chronic Only ^g	0.00	7.69	23.07	23.08	15.38	38.46	13
Proprietary Only ^h	0.00	8.43	61.44	22.89	10.84	4.82	83
Public Hospitals ⁱ	0.00	3.33	26.66	30.00	40.00	3.33	30
Total: All Attdng.	0.10	8.83	50.10	30.16	18.06	1.69	1008
UNAFFILIATED ^j	0.00	10.75	34.94	29.57	16.13	19.35	186
PARTIAL AFFILIATION ONLY ^k	0.00	17.91	50.75	29.85	19.40	0.00	67
CONSULTING ONLY ^l	0.73	0.73	3.65	3.65	21.17	71.53	137
ALL PHYSICIANS	0.14	8.70	43.21	27.30	18.25	11.24	1414
Jewish General ^m	0.00	7.22	45.36	30.93	22.68	1.03	194
St. Mary's ⁿ	0.00	7.32	43.91	28.05	28.05	0.00	82

Footnotes: see following pages

TABLE G:1.--Continued

^aPhysicians with full staff privileges.

^bThe hospitals of categories G1, G2, G3, G4, G5, S1, S2, and S3. See Tables B:2 and B:11 in Appendix B.

^cPhysicians whose only attending-staff affiliation among the categories named in "b" above, is at one or more hospitals of categories G1 and S1.

^dPhysicians whose only attending-staff affiliation among the categories named in "b" above, is at one or more hospitals of categories G2, G3, G4, and S2.

^ePhysicians whose only attending-staff affiliation among the categories named in "b" above, is at one or more hospitals of categories G5 and S3.

^fAll physicians who have more than one attending-staff affiliation among two or three of the categories, major teaching, partial teaching and non-teaching.

Note: All attending physicians at the hospitals referred to in notes "b to f" above are included in the voluntary general and acute-special hospital sub-categories except for 9 attending physicians at the public hospitals. Any attending physicians at both a voluntary general, and a proprietary or chronic hospital, for example, have been included in the former and excluded from the latter categories.

^gPhysicians whose only attending-staff affiliation is at one or more hospitals of categories S4 and S5.

^hPhysicians whose only attending-staff affiliation is at one or more hospitals of category G6.

ⁱAll physicians affiliated with the public hospitals of categories G7 and S6. Although 9 of these 30 physicians have attending-staff affiliation at one of the voluntary general hospitals, they are all considered to be "full-time medical staff" of the public hospitals (information from hospital officials). The 9 physicians have been excluded from the statistics on voluntary general-hospital physicians presented in Tables G:1 to G:8.

TABLE G:1.--Continued

^jNo formal affiliation to an English-Montreal hospital.

^kPhysicians with something less than full staff privileges--variously called visiting, courtesy, temporary, out-patient, adjunct (or member of general practice department in the case of one hospital: see Table B:8 note i)--who have neither attending nor consulting membership at an English-Montreal hospital.

^lPhysicians with consulting, consulting specialist, or honorary attending membership at an English-Montreal hospital, but no attending or partial-affiliation membership. Note: the types mentioned in notes a, k, and l are discussed more fully in Appendix A, Hospitals section.

^mAll physicians with attending-staff affiliation at the Jewish General. These physicians are also included, as applicable, in the categories "partial-teaching only" and "duplicates." Forty-six physicians are duplicates.

ⁿAll physicians with attending-staff affiliation at St. Mary's. These physicians are also included, as applicable, in the categories "partial-teaching only" and "duplicates." Thirty-two physicians are duplicates.

TABLE G:2.--Percentage distribution of physicians by type of hospital affiliation, and by sex, by number of years of practice in Quebec, and by number of years since graduation from medical school

Type of Hospital Affiliation ^a	Sex: Female	Duration of Quebec Practice: Years ^b			Years Since Graduation				N (100%)
		Under 5	5 to 29	30 and over	Under 10	10 to 19	20 to 29	30 and over	
	%	%	%	%	%	%	%	%	
ATTENDING PHYSICIANS:									
Voluntary General and Acute-Special Hospitals:									
Major Teaching) (TH)	10.54	17.17	74.69	8.13	11.75	45.78	27.71	14.76	332
Partial Tchg.	4.55	8.39	77.62	13.99	11.19	39.16	23.43	26.22	286
Non-teaching	13.92	13.92	86.07	0.00	16.45	51.90	26.58	5.06	79
Duplicates	7.03	11.35	82.70	5.95	6.49	47.56	35.13	10.81	185
Chronic Only	0.00	7.69	38.45	53.85	7.69	23.08	15.38	53.85	13
Proprietary Only	3.61	7.23	86.74	6.02	24.09	42.17	20.48	13.25	83
Public Hospitals	6.67	3.33	79.99	16.67	6.67	30.00	26.67	36.67	30
Total: All Attndg.	7.64	12.00	78.57	9.42	11.81	43.65	26.98	17.56	1008
UNAFFILIATED	18.82	24.19	54.83	20.97	13.97	29.03	24.19	32.80	186
PARTIAL AFFILIATION ONLY	4.48	17.91	79.11	2.99	23.89	38.81	22.39	14.93	67
CONSULTING ONLY	4.38	3.65	14.60	81.75	0.73	4.38	5.84	89.05	137
ALL PHYSICIANS	8.56	12.94	68.89	18.18	11.53	37.27	24.19	27.02	1414
Jewish General	1.55	3.09	82.48	14.43	10.82	38.15	29.90	21.13	194
St. Mary's	3.66	8.54	81.71	9.76	6.10	41.46	25.61	26.83	82

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bNumber of years since first licensed to practice medicine in Quebec.

TABLE G:3.--Percentage distribution of physicians with Quebec College specialty certification by type of hospital affiliation and by specialty category

Type of Hospital Affiliation ^a	Specialty Category: Quebec College Certification ^b						
	Medicine ^c	Surgery ^d	Paediatrics	Psychiatry	Obstetrics/ Gynecology	Non-Clinical Specialties ^e	N ^f (100%)
	%	%	%	%	%	%	
ATTENDING PHYSICIANS:							
Voluntary General and Acute-Special Hospitals:							
Major Teaching) ATTO	31.27	26.06	9.12	12.38	7.17	16.94	307
Partial Tchg.	32.89	28.07	0.88	14.04	8.33	16.67	228
Non-Teaching	18.37	36.73	2.04	8.16	12.24	22.45	49
Duplicates	22.53	21.98	26.37	7.69	12.64	10.44	182
Chronic Only	22.22	44.44	11.11	11.11	11.11	0.00	9
Proprietary Only	9.09	59.09	0.00	0.00	13.64	22.73	22
Public Hospitals	50.00	0.00	0.00	16.67	5.56	27.78	18
Total: All Attndg.	28.71	26.87	9.82	11.29	9.20	15.95	815
UNAFFILIATED	15.38	13.46	7.69	17.31	5.77	40.38	52
PARTIAL AFFILIATION ONLY	38.89	22.22	0.00	27.78	0.00	11.11	18
CONSULTING ONLY	36.73	41.84	7.14	2.04	7.14	7.14	98
ALL PHYSICIANS	28.99	27.58	9.33	11.03	8.73	16.05	9978, ^h
Jewish General	33.13	24.10	14.46	12.05	7.23	10.84	166
St. Mary's	33.75	32.50	6.25	7.50	10.00	10.00	80

Footnotes: see following page.

TABLE G:3.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bSpecialty categories correspond to the main departments and functions usually found in a general hospital. After consultation with the Quebec Federation of Medical Specialists, the following borderline specialties were classified, neuro-psychiatry and haematology as medical specialties, and clinical pathology as a non-clinical specialty, Neuro-psychiatrists number 3 among all physicians.

^cComprises allergy, cardiology, dermatology and syphilology, gastro-enterology, haematology, public health, chest diseases and tuberculosis, internal medicine, physical medicine and rehabilitation, neuro-psychiatry, and neurology.

^dComprises general surgery, orthopedic surgery, plastic and reconstructive surgery, cardio-vascular and thoracic surgery, neuro-surgery, ophthalmology, oto-rhinolaryngology, and urology.

^eComprises anatomical pathology, anesthesia, bacteriology, medical biochemistry, clinical pathology, and diagnostic and therapeutic radiology. These are sometimes called "auxiliary specialties" since the physicians either have no contact with patients or else do not have primary responsibility for the patient's hospital care. Therapeutic radiologists number 29 among all physicians.

^fBecause of duplication among specialty categories the percentages usually add up to slightly more than 100%. We may note that, while 201 of these Quebec College specialists have two certifications and 3 have three certifications, only 17 multiple certifications are among different specialty categories.

^gAnother 59 physicians have certification by the Royal College but not by the Quebec College. They are excluded throughout this table.

^hThis table does not present all the Canadian specialty certification of these physicians, since 805 of the 997 have Royal College certification as well. This certification may be in the same specialty, in different specialties or in different specialty categories; and it may be multiple certification by the Royal College. Of the 997 physicians 192, 19.3%, have certification by the Quebec College only.

TABLE G:4.--Percentage distribution of physicians by type of hospital affiliation and by main professional activity

Type of Hospital Affiliation ^a	Main Professional Activity ^b						N (100%)
	Patient Treatment ^c	Research ^d	Teaching ^e	Administration ^f	Industrial Medicine ^g	Other ^h	
	%	%	%	%	%	%	
ATTENDING PHYSICIANS:							
Voluntary General and Acute-Special Hospitals:							
Major Tchg. Only	73.19	7.83	6.33	3.31	0.90	8.43	332
Partial Tchg. Only	87.76	1.05	1.40	2.10	1.40	6.29	286
Non-Tchg. Only	92.41	1.27	0.00	0.00	0.00	6.33	79
Duplicates	92.43	1.62	3.78	1.62	0.00	0.54	185
Chronic Only	92.31	0.00	0.00	7.69	0.00	0.00	13
Proprietary Only	95.18	1.20	0.00	0.00	2.41	1.20	83
Public Hospitals	73.33	0.00	0.00	16.67	0.00	10.00	30
Total: All Attdng.	84.42	3.37	3.17	2.58	0.89	5.56	1008
UNAFFILIATED	72.04	3.23	1.08	6.99	10.22	6.45	186
PARTIAL AFFILIATION ONLY	77.61	2.99	0.00	5.97	10.45	2.99	67
CONSULTING ONLY	83.21	2.19	2.19	5.11	3.65	3.65	137
ALL PHYSICIANS	82.53	3.18	2.62	3.54	2.83	5.30	1414
Jewish General	91.24	2.06	2.06	1.03	0.52	3.09	194
St. Mary's	93.90	0.00	1.22	0.00	0.00	4.88	82

Footnotes: see following page.

TABLE G:4.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bSee Quebec College questionnaire Question C1, Appendix F Item 2. "Main" activity in terms of number of hours worked.

^cComprises general practice and specialist treatment of patients.

^dComprises research in a hospital and other medical research.

^eComprises teaching in basic sciences and clinical disciplines.

^fComprises hospital and other types of administration.

^gComprises industrial medicine and insurance company examiner.

^hComprises laboratory medicine, preventive medicine, and "other."

TABLE G:5.--Percentage distribution of physicians by type of hospital affiliation, and by professional activity and number of professional activities

Type of Hospital Affiliation ^a	Main, Second or Third Professional Activity ^{b,c}						Multiple Activities		N (100%)
	Patient Treatment	Research	Teaching	Administration	Industrial Medicine	Other	Two Activities ^d	Three Activities	
	%	%	%	%	%	%	%	%	
ATTENDING PHYSICIANS:									
Voluntary General and Acute-Special Hospitals:									
Major Tchg. Only	86.44	34.64	74.40	10.54	5.12	11.44	30.42	46.08	332
Partial Tchg. Only	98.25	14.33	24.12	5.60	13.29	11.54	25.17	20.98	286
Non-Tchg. Only	97.47	3.81	6.33	3.80	13.92	8.86	21.52	6.33	79
Duplicates	98.38	19.46	56.75	8.10	3.78	4.32	31.35	29.73	185
Chronic Only	115.38 ^e	0.00	0.00	23.07	7.69	15.38	15.38	23.08	13
Proprietary Only	101.20 ^e	4.81	4.81	6.02	16.87	4.81	16.87	10.84	83
Public Hospitals	80.00	16.67	20.00	23.33	3.33	13.33	16.67	20.00	30
Total: All Attndg.	94.25	20.23	43.25	8.33	8.83	9.53	26.69	28.87	1008
UNAFFILIATED	78.49	9.14	13.45	8.61	16.67	25.81	32.80	9.68	186
PARTIAL AFFILIATION ONLY	86.57	10.45	19.41	7.46	28.36	11.95	28.36	17.91	67
CONSULTING ONLY	93.43	11.68	12.41	7.30	8.03	35.04	41.61	13.14	137
ALL PHYSICIANS	91.87	17.33	34.80	8.14	10.75	14.35	28.85	24.19	1414
Jewish General	99.49	18.55	26.80	4.12	10.83	7.21	22.68	22.16	194
St. Mary's	97.56	13.42	39.03	6.10	10.98	9.76	32.93	21.95	82

Footnotes: see following page.

TABLE G:5.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bActivity categories are described in notes "c to h" in Table G:4.

^cThis table displays the percentage of physicians who have an activity category as either their main, second or third professional activity in terms of number of hours worked.

^dThe percentage of physicians who report two activities, excluding those who report three activities.

^eThis is possible because some physicians report general practice as their main activity, say, and specialty practice as their second or third activity.

TABLE G:6.--Percentage distribution of physicians by type of hospital affiliation and by main source of professional income

Type of Hospital Affiliation ^a	Main Source of Professional Income ^b						N (100%)
	Self-Employment	Hospital	Government ^c	University	Industry ^d	Other ^e	
	%	%	%	%	%	%	
ATTENDING PHYSICIANS:							
Voluntary General and Acute-Special Hospitals:							
Major Tchg. Only	61.75	22.89	2.11	9.64	2.71	0.90	332
Partial Tchg. Only	80.07	16.78	0.00	1.05	1.40	0.70	286
Non-tchg. Only	83.54	13.92	2.53	0.00	0.00	0.00	79
Duplicates	81.62	15.68	0.54	2.16	0.00	0.00	185
Chronic Only	69.23	30.77	0.00	0.00	0.00	0.00	13
Proprietary Only	87.95	7.23	1.20	0.00	2.41	1.20	83
Public Hospitals	13.33	20.00	66.67	0.00	0.00	0.00	30
Total: All Attdng.	73.12	17.86	3.08	3.87	1.49	0.60	1008
UNAFFILIATED	63.44	14.52	5.91	3.23	12.37	0.54	186
PARTIAL AFFILIATION ONLY	68.66	10.45	4.48	0.00	14.93	1.49	67
CONSULTING ONLY	81.75	6.57	0.73	5.11	5.11	0.73	137
ALL PHYSICIANS	72.77	15.77	3.25	3.68	3.89	0.64	1414
Jewish General	84.54	12.37	0.52	1.55	0.52	0.52	194
St. Mary's	86.59	9.76	1.22	1.22	0.00	1.22	82

Footnotes: see following page.

TABLE G:6.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bSee Quebec College questionnaire Question C2, Appendix F Item 2. "Main" source refers to hours worked rather than income earned.

^cComprises departments or agencies of the provincial government (except the Workmen's Compensation Commission), the federal government and municipalities.

^dComprises insurance companies, pharmaceutical companies or other industries.

^eThe response-category "other."

TABLE G:7.--Percentage distribution of physicians by type of hospital affiliation, and by source of professional income and number of income sources

Type of Hospital Affiliation ^a	Main, Second or Third Source of Professional Income ^{b,c}						Multiple Sources		N (100%)
	Self-Employment	Hospital	Government	University	Industry	Other	Two ^d Sources	Three Sources	
	%	%	%	%	%	%	%	%	
ATTENDING PHYSICIANS:									
Voluntary General and Acute-Special Hospitals:									
Major Tchg. Only	79.22	45.18	12.35	44.28	8.13	2.71	38.86	26.51	332
Partial Tchg. Only	89.16	33.22	4.20	12.24	12.94	2.10	30.07	11.89	286
Non-tchg. Only	87.34	22.78	5.06	5.06	12.66	0.00	17.72	7.59	79
Duplicates	92.97	38.92	12.97	28.11	5.40	4.32	31.89	25.41	185
Chronic Only	84.61	38.46	23.08	7.69	0.00	0.00	38.46	7.69	13
Proprietary Only	92.77	13.25	3.61	1.20	16.87	1.20	14.46	7.23	83
Public Hospitals	36.66	33.33	73.34	6.67	3.33	0.00	40.00	6.67	30
Total: All Attdng.	85.13	35.81	10.82	24.01	9.82	2.39	31.45	18.25	1008
UNAFFILIATED	73.12	17.75	9.14	8.60	19.36	2.15	18.28	5.91	186
PARTIAL AFFILIATION ONLY	79.11	22.40	8.96	7.47	29.86	2.98	26.87	11.94	67
CONSULTING ONLY	87.59	10.22	5.11	13.87	10.22	1.46	17.52	5.84	137
ALL PHYSICIANS	83.66	30.06	9.90	19.95	12.09	2.27	28.01	14.99	1414
Jewish General	93.30	28.86	6.19	12.38	10.31	2.07	30.41	11.34	194
St. Mary's	95.13	29.27	9.76	21.95	10.98	4.88	32.93	19.51	82

285

Footnotes: see following page.

TABLE G:7.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bIncome-source categories are described in notes "c to e" in Table G:6.

^cThis table displays the percentage of physicians who have an income category as their main, second or third source of professional income, in terms of the number of hours worked.

^dThe percentage of physicians who report two sources, excluding those who report three sources.

TABLE G:8.--Percentage distribution of physicians by form of remuneration, and by preferred language

Type of Hospital Affiliation ^a	Form of Remuneration ^b			Preferred Language: French ^e	N (100%)
	Fee-for Service Only	Salary and fee-for-service ^c	Salary Only ^d		
	%	%	%	%	
ATTENDING PHYSICIANS:					
Voluntary General and Acute-Special Hospitals:					
Major Tchg. Only	41.57	50.00	8.43	9.64	332
Partial Tchg. Only	66.08	29.02	4.90	6.99	286
Non-tchg. Only	75.95	20.25	3.80	24.05	79
Duplicates ^f	52.97	45.95	0.54	3.24	185
Chronic Only	61.54	23.08	15.38	30.77	13
Proprietary Only	83.13	13.25	3.61	65.06	83
Public Hospitals	13.33	43.33	43.33	30.00	30
Total: All Attndg. ^f	56.15	37.40	6.35	14.29	1008
UNAFFILIATED	60.75	15.59	23.66	0.00	186
PARTIAL AFFILIATION ONLY	52.24	29.85	17.91	0.00	67
CONSULTING ONLY	71.53	15.33	13.14	0.00	137
ALL PHYSICIANS ^f	58.20	31.97	9.76	10.18	1414
Jewish General	69.07	28.87	2.06	4.12	194
St. Mary's	58.54	40.24	1.22	8.54	82

Footnotes: see following page.

TABLE G:8.--Continued

^aHospital affiliation categories are described in notes "a to n" in Table G:1.

^bSee Quebec College questionnaire Question C3, Appendix F Item 2.

^cIncludes those who report scholarships, fellowships, grants, or profit from operation of a pharmacy in addition to fees-for-services.

^dIncludes, in addition to those who report salary only, those who report scholarships, fellowships, grants, or profit from operation of a pharmacy either alone or in connection with a salary.

^eThe language in which the physician wishes to receive all communications from the Quebec College. We may note that 143 physicians have French ethnic origin, while 144 have French as their preferred language; our computer output does not show whether these are the same persons.

^fThe form-of-remuneration classes do not add up to 100% because the variable was not given for one physician in this category.

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