INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
A sociohistorical analysis of the crown-based health ensembles (CBHEs) in Hawaii: A Sartrean approach

Kamakahi, Jeffrey Jon, Ph.D.

University of Hawaii, 1991

Copyright ©1991 by Kamakahi, Jeffrey Jon. All rights reserved.
A SOCIOLAGICAL ANALYSIS OF THE
CROWN-BASED HEALTH ENSEMBLES (CBHES) IN HAWAII:
A SARTREAN APPROACH

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE
UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

SOCIOLOGY

MAY 1991

by

Jeffrey J. Kamakahoi

Dissertation Committee:

Eldon Wegner, Chairperson
Harry V. Ball
Kiyoshi Ikeda
Deane Neubauer
Abraham Pi'ianai'a
Albert B. Robillard
DEDICATION

I dedicate this dissertation to my three soul mates: Katie, Lindsay, and Hattie. You have taught me so much about living and have certainly given me more than my share of happiness. I love you.
ACKNOWLEDGEMENTS

A sociologist, perhaps more than others, should be acutely aware that a dissertation like this one is a social production of astonishing complexity. Without the effort and cooperation of numerous people, both conspicuous and unsung, the final product would never come to fruition. In these few short paragraphs, I hope to identify some of those who have been especially helpful.

First, I would like to thank the members of my dissertation committee. Eldon Wegner has been supportive of my efforts throughout this ordeal while continually having to remind me to stay within the realm of medical sociology. Harry Ball, our resident expert on the sociology of law and the Hawaiian Kingdom, has kept me honest with regard to historical grounding and personal networks. Kiyoshi Ikeda has provided a wealth of information on the cultural complexities in Hawaii as well as being a continual believer in my abilities as a scholar and a public relations committee of one. Deane Neubauer assured that my sociologese could also be understood by non-sociologists and was particularly helpful with the incorporation of political-economic influences in the interpretation of events. Abe Pi'ianai'a, noted Hawaiian scholar, provided
the knowledge of his years and experience in pointing out certain nuances and networks in Hawaiian and political circles. Britt Robillard was particularly influential in arduously converting me to "postmodernism": this work being a moderate step in that direction. I'd like to thank the members of my committee both individually and collectively. And I would like to recognize Michael Weinstein for acting as a proxy member of the committee for my oral defense.

There are several others associated with the Department of Sociology that I would like to acknowledge as well. Heather Hammer, with whom I've worked on countless computer runs, datasets, and projects has allowed me to develop my "methodological and quantitative selves". Lloyd Kuniyoshi has always been available to remedy my ignorance of computers and certain facets of data management and analysis whenever they arose. The "Local Connection", Keith Nagai, Wesley Uenten, Lloyd Kuniyoshi, and others often "power lunched" through many a trial and tribulation; thanks to them all. Deanna Chang was her immutable, micro-functionalist self at all times. Richard Chabot and I struggled along parallel paths in an attempt to traverse our graduate careers. I wish to express thanks to all graduate students and students of sociology in general with whom I have come into contact.

I wish to recognize Helen, Jessie, and Jan, staff of the Department of Sociology, and Lincoln for their
formidable assistance and companionship throughout my years at the University of Hawaii. It would be no exaggeration to say that they kept me abreast of many important deadlines and events.

The Department of Sociology, the Hawaiian Studies Program, and Minority Fellowship Program of the American Sociological Association, and assorted contracts have provided me with financial support and assistance over the past five years. This project would never have been completed without them.

Finally, I would like to thank my family for "doing without" for so long so that I could research, write, and revise various versions of this project and complete the various stages of my graduate career. I couldn't imagine accomplishing anything of this or any magnitude without their cooperation.
ABSTRACT

The expansion of Western powers into the Pacific reached Hawaii in the 18th century. Within the course of a century and a half, Hawaiian society was transformed from an isolated Polynesian culture into part of the world's most hegemonious world power. This study examines the historical development of four focal health care institutions within the context of such rapid political-economic and socio-cultural transformations.

The emergence of philanthropy epitomizes this Western influence. Its appearance merged the general commodification of space and time, the decimation of the Native Hawaiian cultural practices and population, and the arrival of early capitalism. The Crown-Based Health Ensembles (CBHEs) marked the use of philanthropy on the part of the Native Hawaiian aristocracy's Western weltanschauung with the adoption of an interventionist and reductionist "clinical gaze".

Jean-Paul Sartre's theory of practical ensembles is employed as a theoretical heuristic by which to characterize moments in the CBHE trajectories. Practical ensembles are collectivities of various types. Sartre's framework provides the means by which institutional discontinuities
can be situated within the relevant milieu which surround them. Project definitions and redefinitions are continually linked to institutional policy as well as to socio-cultural and political-economic contexts. Each of the four institutions is seen as a case within the broader CBHE panel.

The historicity of concepts and the emergent properties of societal reorganization are constantly highlighted. Three themes, though, are settled upon as coordinates to assess the overall movement of the CBHEs and the structuration of the health sector in this interpretive study. The three themes are universality (i.e., the characteristics which underlie notions of equal access), social buffers (i.e., the extent to which institutions are encompassed by intermediary agencies), and health sector position (i.e., the location of an institution in relation to the political-economic contours of the health practice).

The study concludes by arguing that the trajectories of institutions cannot be accounted for by determinist, reductionist perspectives which assume contextual homogeneity. Sartre's orientation is viewed as a viable non-determinist, non-reductionist approach to the study of ensembles.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>iv</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>v</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xiii</td>
</tr>
<tr>
<td>PREFACE</td>
<td>xiv</td>
</tr>
<tr>
<td>CHAPTER 1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The Crown-Based Health Ensembles (CBHEs)</td>
<td>4</td>
</tr>
<tr>
<td>The Theoretical Construct</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical Orientation</td>
<td>8</td>
</tr>
<tr>
<td>A Sartrean Approach</td>
<td>9</td>
</tr>
<tr>
<td>The Progressive/Regressive Method</td>
<td>10</td>
</tr>
<tr>
<td>Practical Ensembles</td>
<td>13</td>
</tr>
<tr>
<td>Ensemble Categories Versus Ideal Types</td>
<td>16</td>
</tr>
<tr>
<td>A Sartrean Approach to the Study of the CBHEs</td>
<td>17</td>
</tr>
<tr>
<td>Method: A Study of Documents</td>
<td>19</td>
</tr>
<tr>
<td>Documents as Social Productions</td>
<td>19</td>
</tr>
<tr>
<td>Outline of the Dissertation</td>
<td>22</td>
</tr>
<tr>
<td>CHAPTER 2. THE CONTEXT OF PHILANTHROPY</td>
<td>26</td>
</tr>
<tr>
<td>Philanthropy: Transfer of Private Wealth</td>
<td>26</td>
</tr>
<tr>
<td>Dissection of Philanthropy</td>
<td>28</td>
</tr>
<tr>
<td>Aspects of Philanthropy</td>
<td>29</td>
</tr>
<tr>
<td>Setting the Stage</td>
<td>32</td>
</tr>
<tr>
<td>Accumulation</td>
<td>34</td>
</tr>
<tr>
<td>Humanitarianism</td>
<td>39</td>
</tr>
<tr>
<td>Societal &quot;Needs&quot;</td>
<td>41</td>
</tr>
<tr>
<td>Emergence of a Westernized Hawaii</td>
<td>43</td>
</tr>
<tr>
<td>The Continuing Legitimation</td>
<td>45</td>
</tr>
<tr>
<td>Discussion</td>
<td>47</td>
</tr>
<tr>
<td>CHAPTER 3. THE QUEEN'S HOSPITAL</td>
<td>49</td>
</tr>
<tr>
<td>Organization: Charter of Incorporation, 1859</td>
<td>50</td>
</tr>
<tr>
<td>The Sovereigns</td>
<td>53</td>
</tr>
<tr>
<td>Subscribers' Trustees</td>
<td>56</td>
</tr>
<tr>
<td>Government Trustees</td>
<td>58</td>
</tr>
<tr>
<td>The Quasi-Public Institution</td>
<td>59</td>
</tr>
<tr>
<td>Seriality: Before the Conception, pre-1854</td>
<td>60</td>
</tr>
<tr>
<td>Western Contact</td>
<td>61</td>
</tr>
<tr>
<td>Health, Illness, and Treatment in the Early Kingdom Era</td>
<td>65</td>
</tr>
<tr>
<td>Hospitals: 1800 - 1854</td>
<td>68</td>
</tr>
</tbody>
</table>
## CHAPTER 7. THE CROWN-BASED HEALTH ENSEMBLES (CBHEs)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualizing the Panel</td>
<td>216</td>
</tr>
<tr>
<td>Structural Characteristics</td>
<td>217</td>
</tr>
<tr>
<td>Latent Factors</td>
<td>221</td>
</tr>
<tr>
<td>Social Buffers</td>
<td>221</td>
</tr>
<tr>
<td>Universality</td>
<td>224</td>
</tr>
<tr>
<td>Sector Position</td>
<td>227</td>
</tr>
<tr>
<td>Latent Factors</td>
<td>229</td>
</tr>
<tr>
<td>Inter-relationships Between Latent Factors</td>
<td>230</td>
</tr>
<tr>
<td>Social Buffers and Universality</td>
<td>231</td>
</tr>
<tr>
<td>Social Buffers and Health Sector</td>
<td>232</td>
</tr>
<tr>
<td>Universality and Health Sector</td>
<td>233</td>
</tr>
<tr>
<td>The Political-Economy of Health in Hawaii</td>
<td>234</td>
</tr>
<tr>
<td>The CBHEs as a Microcosm</td>
<td>236</td>
</tr>
</tbody>
</table>

## CHAPTER 8. DISCUSSION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of the Project</td>
<td>238</td>
</tr>
<tr>
<td>Toward a Non-Reductionist, Non-determinist Orientation</td>
<td>241</td>
</tr>
<tr>
<td>Limitations and Possible Extensions of the Project</td>
<td>244</td>
</tr>
<tr>
<td>Concluding Remarks</td>
<td>250</td>
</tr>
</tbody>
</table>

## BIBLIOGRAPHY

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>252</td>
</tr>
</tbody>
</table>
LIST OF TABLES

TABLE 1. CBHEs With Regard to Focal Characteristics .................................. 220
This dissertation came about as a personal attempt to merge a number of interests into a single project. Among these various threads were interests in: (1) the health status of Native Hawaiians; (2) the historical development of health practices and institutions; (3) the study of discourse; and (4) the efficacy of Sartrean thought in sociological analysis.

As a strategy for analysis, I attempted to act primarily as an organizer of discourse; though even this, no doubt, was textured by theoretical interests and decisions of topical interest. The general approach was intent upon situating different "critical" periods of institutional trajectories in accordance to those indexically expressed by participants; though the act of "situating" itself required texturing the scenes and the drama. The strategy of "situating" is rather convoluted: moving back and forth in time and leaving yarns tentatively unraveled at many junctures. Hopefully, by the end of the study, the yarns are sufficiently knitted together.

One who expects detailed history, in-depth philosophical discussions, and/or polemic politicism will be disappointed in the study and would best look elsewhere. However, those interested in the complexities and
intermeshing of political-economic, cultural, and social
transformations, especially as they relate to Native
Hawaiians and some focal health institutions, may be urged
to read on.
CHAPTER 1
INTRODUCTION

The for-itself is contemporary with the in-itself, inasmuch as it is vested by it; but the world is the future for is, as much as it lacks the world. ... Each thing is an immediate presence that we can reach only in the future. Such is the meaning of the transcendence or surpassing of the vesting present towards the "thing-to-come" of the world. (Sartre, 1984a: 234)

Socio-historical studies of localized health processes have recognized the importance of explicating the reciprocal influence of practitioners, policies, and the socio-political phenomenon which encompass them (Doyal, 1975; Starr, 1982; Navarro, 1976, 1978; Foucault, 1973; E.R. Brown, 1979; Freidson, 1963; Danielson, 1979; Rosen, 1983; Rosenberg, 1987; Rothman, 1971; Vogel, 1980). In such endeavors, issues of central import have revolved around the particular manner in which health/medical practices\(^1\) evolve and the influences which texture development in specific directions.

In this study, attention is focused upon the intersection of health/medical practices as they were influenced by the Western expansion into 18th and 19th

---

\(^1\) In this project the term "health practices" will be given quite broad parameters. Health practices will be those interventionist activities performed by culturally or State legitimized health providers. In particular, Western allopathic medicine will be the focus although traditional healers (i.e., kahuna lapa'au), homeopathy, and other categories of healing activities could be included.
century Hawaii from their genesis. The historical infiltration of Western health practice and its accompanying ethos represented a significant change from that of traditional Native Hawaiian medicos (Blaisdell, 1989; Gutmanis, 1985; Larson, 1944). The catalysts of this process were agencies which explicitly employed Western health practices in the form of hospitals, maternity homes, nursing homes, and orphanages. The emergence of these "asylums" not only legitimated Western health practices, but concomitantly served to rebuke traditional definitions of health and illness, holism, and intervention.2

Despite their importance, the creation and subsequent development of Western health care institutions in Hawaii has received scant scholarly attention. Those studies that have been generated fall within one of the following categories: general organizing schemes (Kamakahi, 1989a, n.d.); chronological or synchronic studies of single institutions (Talmadge, 1989; Kamakahi, 1989c; Yardley and Rogers, 1979; Greer, 1969; Houston, 1939, 1950); biographies of individuals associated with institutions (Halford, 1954); and general chronologies of medical care (Blaisdell, 1989; Nebelung and Schmitt, 1948). There has not, however, been a comprehensive socio-historical study of a set of focal

---

2 The term "asylum" is used in the manner consistent with Rothman (1971): that is, those institutions specifically designed to isolate and treat its tenants. Goffman's (1961) discussion of asylums would represent an extreme depiction.
health institutions; that is, no study has attempted to systematically link changes in institutionalized health practice and policy with larger currents of political-economic and socio-cultural transformations. This study is an attempt to rectify this deficiency.

This investigation presents a socio-historical study of four related, but unique, health institutions in Hawaii. The trajectories of these institutions, the Crown-Based Health Ensembles (CBHEs), will be traced temporally and situated with respect to relevant milieu.

The remainder of this chapter discusses the contours of the study. First, there will be a discussion of the fruitfulness of the CBHEs heuristic and the issues identified by its employment. Then, there will be a brief explication of the orientation used in this project: specifically, Sartre's (1967, 1976) progressive/regressive method and theory of practical ensembles. Third, the methodology employed in this study will be discussed. And finally, a synopsis of the chapters in this research project will be presented.

---

3 The term trajectory is used in a similar sense to that of Strauss (1975): to refer to the historical, contextual development. While Strauss has been interested in micro-orders composed of individuals, this study is interested in macro-orders composed of actors which are themselves social aggregates.

4 The Crown-Based Health Ensembles (CBHEs) conception is a nominal modification of the label Crown-Based Health Care Legacies developed by Kamakahi (1989b) to refer to the same set of institutions.
The Crown-Based Health Ensembles (CBHEs)

This project studies four Hawaii health institutions created to address various aspects of social and physical well-being. Despite their concrete differences, the institutions in question, the Queen's Hospital, the Lunalilo Home, the Kapiolani Home, and the Liliuokalani Children's Center, share many theoretically pertinent commonalities. It is argued that these theoretical likenesses, which will be revealed in the next subsection, warrant their collective grouping under the CBHE rubric (see Kamakahi, 1989b).

CBHEs: The Theoretical Construct

This study posits the existence of a shared theoretical thread between Queen's Hospital, Lunalilo Home, Kapiolani Maternity Home, and Liliuokalani Children's Center: the CBHEs. This section will identify the six major dimensions upon which the CBHE heuristic rests.

First, the creation of each CBHE is intimately associated with the sovereigns of Hawaii's later Kingdom era. These institutions are "crown-based" because much of the impetus for their establishment (e.g., the identification of the health issue to be addressed, the securing of funds, the mobilization of structures) was located in the Crown itself - often acting as an agent for deliberate social change in both a symbolic and official capacity. Here, the cultural legitimacy of the Crown often
extended beyond the purview of official political parameters.

A second commonality is that each CBHE was established, at least in part, by philanthropic effort. The issue of philanthropy is an essential feature of impinging Westernization and the effects of the commodification and wealth stratification which was emerging. The instanciation of philanthropy as a means for deliberate social change required a dramatic transformation in social organization and political-economy.

Third, each CBHE was concerned specifically with the health (i.e., social and/or physical well-being) of Native Hawaiians in the form of specifically created institutional structures. The institutional approach to social problems implied: (1) that there was a defined societal health problem that was significant enough to warrant special attention and (2) that the means of previously addressing such an issue were either non-existent or inadequate. The rationalization of institutional forms provided a forum for breaking with traditional practices.

Fourth, each CBHE signified an interventionist approach to issues as defined by an introduced Western lexicon. It is important to note that the diffusion of Western health/medical practices was accomplished through the elite
of the traditional Native Hawaiian society. The adoption of the foreign lexicon, thus, was bolstered (and legitimized) through the already existent status hierarchy. The adopted interventionist approach was associated with an entirely new "theory of the body": viewing the body as an object for intervention rather than as a holistic totality.

Fifth, the CBHEs were each originally concerned with serving the Native Hawaiian populous (i.e., where Native Hawaiian is a recognized legal category). Native Hawaiians were specifically identified as either the exclusive or as the primary target population. This issue is important when "Hawaiian" would later take on two disparate meanings: (1) as an ethnic category for indigenous peoples or (2) as a spatial category applied to those occupying the territorial boundaries of the Hawaiian Islands.

Sixth, and lastly, each CBHE was originally "buffered" from a market, for-profit orientation by mediating agencies. None of these institutions began as a market-based facility; they were funded through private philanthropic entities.

---

5 Actually, what existed at the time was a quasi-traditional arrangement given that the Kingdom was a new political form not strictly based upon previous modes of succession.

6 See Foucault (1973) and Turner (1987) on their discussions of the body as a newfound object of inquiry independent of the mind and/or soul.

7 These would be different from the use of the term as a legal category based upon race or as a citizenship in the Hawaiian nation.
and/or the State. Monetary profit, then, was not a primary consideration. The subsequent dialectic between institutions and political-economic contexts becomes constantly played out in the CBHE trajectories when the health market sectors begin to loom larger in the organization of health practice.

These six similarities serve as a framework that can be used to assess the historical trajectories of these institutions as they create traces through the increasingly complex and interpenetrating exigencies of their socio-politico-economic contexts. Questions of particular import include the following:

(1) How, through time, are the CBHEs associated with the State and the sovereigns?

(2) How are health concerns defined and redefined over time?

(3) How has philanthropy influenced the respective development of these institutions?

(4) How have Western and non-Western approaches to health issues been instanciated by the CBHEs?

(5) How has the focus on serving those of the Native Hawaiian ethnicity been transformed?

(6) How has the market-orientation impinged upon institutional practices?

Each theoretical commonality in the CBHE heuristic acts as a basis for comparison. The historical "branching" of
the CBHEs from their similar "roots" allows for the opportunity to investigate each ensemble as a case in a panel or cohort. Thus, the CBHE conceptualization provides a means by which the study of each ensemble informs us as to the efficacy of the panel heuristic; something that would be impossible if just a single ensemble were being studied in isolation.

**Theoretical Orientation**

The CBHEs represent cases within a panel of health institutions, each of which is studied in its historical trajectory. This study employs an interpretive approach for socio-historical analysis (see Skocpol, 1984). The interpretive approach is ideographic and emic. It does not search for causal explanations, but rather employs concepts to develop a meaningful understanding of the phenomena under scrutiny by paying "attention to the orientations of the actors as well as to the institutional and cultural contexts in which they operate" (Skocpol, 1984: 371). In this study, the discursive orientations of actors, both persons and ensembles, are investigated viz-a-viz the semiotic contexts of their appearance.

---

8 In brief, nomothetic orientations attempt to create generalizing schemes while ideographic approaches attempt to capture the particular character of that being studied. Etic refers to an external orientation and emic to the internally informed or generated investigations (Denzin, 1989).
The interpretive approach attempts to allow the data and the orienting strategy to texture one another through the researcher, rather than to impose a priori the status variables and the functional form which relations "must" take. There is assumed to be an iterative dialectic between the theoretical framework and data.

This study is concerned with how changes become manifest rather than "why" events came out as they did. The question of how points to vocabularies of motive used by situated actors within given social orders, whereas the "why" orientation presumes a metaphysic of a unitary, objective reality (see Duncan, 1962; Denzin, 1989). In order to discuss how the trajectories of the CBHEs evolved, the orienting concepts of philosophical writings of Jean-Paul Sartre (1967, 1976) will be employed.

**A Sartrean Approach**

The later writings of Jean-Paul Sartre have received much attention in the social sciences and humanities literature (McBride, 1980; Catalano, 1986; Flynn, 1984; Desans, 1965; Poster, 1982; Jay, 1984; Craib, 1976; Laing and Cooper, 1964; Aronson, 1987a, 1987b; R.H. Brown, 1979; Busch, 1972, 1986; Caws, 1988; Connell, 1982; Gillan, 1980; Hayim, 1980; Hendley, 1988; Imboden, 1987; Sheridan, 1969; Snedeker, 1969; Stack, 1971, 1977; Warnock, 1982; Yovel, 1979). This extensive array of commentaries were produced
in response to Sartre's related works: Search for a Method (1967) and Critique of Dialectical Reason (1976). The advantage of the Sartrean approach is that it is descriptive rather than prescriptive or proscriptive. Because his framework employs a set of interrelated but mutually exclusive categories of relatedness, the method requires the continual re-evaluation of characterizations with regard to any collectivity (i.e., practical ensemble) as it traverses changing social contexts. Sartre's progressive/regressive method⁹ and his theory of practical ensembles will be briefly discussed in the following subsections, because they provide the basic orientation for the investigation.

The Progressive/Regressive Method

Sartre's progressive/regressive method was a response to the "dogmatic Marxism" that he regarded as characterizing the times. The method was opposed to the predetermined, a priori employment of economic categories as constituting analysis proper. Sartre identified two important aspects of methodology which were conspicuously absent in previous reductionist orientations. He argued that situated action

---

⁹ Although refered to as the progressive/regressive method, it represents an orientation rather than a methodology per se. For this reason, it will be discussed as part of this study's theoretical orientation.
and the issue of mediations were essential to any understanding of historical totalizations.\textsuperscript{10}

For Sartre, purposive human action, whether by an individual or collective, is timeful: that is, actors are immersed within a concrete, ongoing present contextualized by constructed pasts and projected futures.\textsuperscript{11}

The progressive-regressive method seeks to situate and understand a particular class of subjects within a given historical moment. Progressively, the method looks forward to the conclusion of a set of acts or actions undertaken by a subject... . The term "progressive" refers here to the forward, temporal dimension of the interpretive process. Regressively, the method works back in time to the historical, cultural, and biographic conditions that moved the subject to take, or experience, the actions being studied. By moving forward and backward in time, the subject's projects and actions are situated in time and space. The unique features of the subject's life are illuminated in the interactional episodes that are studied. The similarities and commonalities shared with others are also revealed. (Denzin, 1989: 21).

Timefulness has two implications. The first implication is that progressive/regressive concerns with temporality organize the understanding of events - that is, situating events is not isomorphic with presenting a strict

\textsuperscript{10} Sartre spoke of totalizations (i.e., the continual process of system depiction) as opposed to totality (i.e., the prescriptive determinacy of wholeness). (See Sartre, 1967; Jay, 1984)

\textsuperscript{11} In this way, Sartre's orientation shares much with the concern for temporality and situated activity as do the symbolic interactionists (see Mead, 1934, 1938, 1959; Blumer, 1969; Couch and Hintz, 1975; Denzin, 1989). (See also Mills, 1940).
chronology. The historical meanings of events requires the explication of the systems of meanings as indexically understood and as depicted within a social context of background assumptions.\(^{12}\)

The second implication of timefulness is that the trajectory of events is marked by critical disjunctures rather than by a continuous, amorphous extension from determinate causes. In short, some events are critical in that they force a definition or redefinition of a project; that is, they are epiphanic.

Concomitant with timefulness in Sartre's orientation is the concern with the notion of mediations. For Sartre, the problem of mediations involves the explication of the relations between actions occurring at various levels of social praxis. Structures are seen as being enabling and/or inertial to situated agents.\(^{13}\)

One of the cardinal premises of Sartre's new praxis philosophy is that "reciprocal ternary relations"\(^{14}\)

\(^{12}\) Ethnomethodologists, post-modernists, semioticists, phenomenologists, and symbolic interactionists share interests in the meanings as they exist as enacted systems reconstructed within concrete situations.

\(^{13}\) The enabling or inertial assessment of collectivities depends upon the position and the intended activity of the assessor.

\(^{14}\) For Sartre, relations are minimally ternary because each actor conceives of himself as subject, the other as object, the himself as object to any consciousness - even his own. Sartre's conception is not all that far removed from that of G.H. Mead (1934) or the Frankfurt School (Jay, 1984; Gottlieb, 1989).
are the basis of all relations between men, whatever form they may subsequently take". The nature of these reciprocities, whether negative (struggle) or positive (cooperation), depends on the mediation of the practico-inert or of praxis 15 respectively. Likewise, the social wholes upon which Sartre's social ontology is grounded express either or both of these mediating factors ... They are best appreciated as constituents of the perennial dialectic of sameness and otherness. (Flynn, 1984: 93).

Synchronously, the focus is upon mediations: how individuals and structures (collectivities) interpenetrate. Diachronically, the progressive/regressive method emphasizes epiphanic (critical) events and their influence upon the definition of the ensemble's project.

Practical Ensembles

In Critique of Dialectical Reason (1976), Sartre is concerned with discussing practical ensembles. A practical ensemble is collectivity of human beings which can be characterized by the prevalence of cohesiveness of its constitutive membership. 16 This cohesiveness, or manner of

15 The practico-inert and praxis represent complementary notions. Since social life is timeful, human activity is simultaneously producing and destroying structures. Sartre conceives of activity as situated and purposeful. Those actions that assist in the actor's or ensemble's accomplishment of it's project (goal) employ praxis (constructive activity), while those activities which thwart the project because of the "mindless reproduction" of structures face the practico-inert (inert to the practical accomplishment of the project).

16 Sartre's view of ontology centers around the individual, even though his later writings focus upon collectivities. Collectivities are thus referred to as a
relatedness, characterizes not only the affective affiliation of its membership, but the way in which the ensemble is "structured" and the means by which it deals with those external to its membership. The categories that Sartre employs for ensembles include the series, the fused group (or, group-in-fusion), the organization, and the institution.¹⁷

The series. The series represents the ensemble with the least amount of cohesion among its constitutive membership. In effect, the series represents a minimum of coordinated activity. It is Sartre's recognition that even when actions between individuals are not mutually coordinated with regard to some overarching project, a "background order" exists. The series represents one way in which individuals are alienated from one another in the guise of civility. In this state of disaggregation, reciprocal "otherness" produces a strong inertial force. At this level, the project per se is nonexistent, though a viable unrealized possibility.

The fused group. The fused group is the antithesis of the series. In practical ensembles of this type, participants are mutually active in attempting to create and constitutive dialectic (i.e., actors).

¹⁷ Only certain aspects of the theory of practical ensembles are explicated here. For example, scarcity, fraternity-terror, the practico-inert, and so on not explicitly employed in this study are omitted.
define a project. There is an explicit pledge by each member to act in terms of the group and to monitor the integrity of others in terms of the pledge. Defining the project becomes the primary emergent exigency of an ongoing present. The formalization of structure is the goal, but the ensemble at his stage is ambiguous and ephemeral. The fused group is transitional and often short-lived.

**The organization.** In the organization form, a formal structure exists concomitant with a positive affective identification for the ensemble among its constitutive membership. Role positions and their networks are denotively parameterized, but there can be substantial "slippage" as such roles are modified by the exigencies of immediate concern. The ensemble possesses structure but no cyclical form of rote reproduction; it is, however, iterative.

**The institution.** The institution, like the organization, is characterized by a formal structure in which role positions are outlined. The major difference between the two lies in the lack of a unifying project coordinating diverse activities and a lack of a strong positive affective identification with the ensemble and its constitutive membership. Like the series, individuals are often alienated from one another and concerned primarily with the functioning of specific sub-units. However, in contrast to the series, the institutional members' actions
are constitutive of an ensemble project: even if such a project seems removed by the layers of diverse formality. Actions are traditional is the sense that structures have become inert.

**Status changes.** There is always the possibility of an ensemble changing from one type of practical ensemble to another: an organization may disintegrate into a series; a fused-group may never settle upon the criteria by which to organize itself; or an institution may even temporarily become a fused-group in order to redefine itself and emerge as another institution quite different from its previous instanciation. There is no prescribed order which status passage must follow; the categories are heuristic tools for characterizing ensembles as they move concretely through time.

**Ensemble Categories Versus Ideal Types**

For Sartre, the ensemble types do not represent real categories, but neither are they simply arbitrary labels. Rather, these categories are heuristic devices which focus attention upon selected aspects of social interaction. In short, the categories of practical ensembles are organizing theoretical tools for identifying verifiable, locally operating processes.

Sartre's categories for practical ensembles in some ways may be seen as analogous to Weberian "ideal types" (see
Weber, 1946). In either case, the heuristic device is constructed as a theoretical and methodological tool. The ideal type, though, is usually a single, static monolith used for synchronic, cross-sectional purposes. Sartre presents a set of heuristic constructions which may be used both synchronically and diachronically. In the latter case, the same ensemble with the same formal structure may nevertheless move between categories by virtue of the informal relatedness of the ensemble membership. While for Weber, ideal type bureaucracies are formal, for Sartre ensembles are seen primarily as informal networks which produce formality.

A Sartrean Approach to the study of the CBHEs

The interpenetration of ensembles as actors, their constitutive membership, and their contexts lies at the heart of the study. As a panel, the CBHEs are nested within the context of Hawaii's socio-politico-economic milieu. For this reason, they will have to be set within the context of Hawaii's tumultuous history: between the period of initial Western contact through its evolution as a kingdom, and on to its present status as a member of a hegemonious world

\[\text{\footnotesize\textsuperscript{18}}\] The notion of produced formality in organized collectivities is discussed also by Tolbert and Zucker (1983), Zucker (1977), Weick (1976), and Meyer and Rowan (1977).
power. This history is a general framework within which each ensemble can be temporally located.

The prospective analysis of each of the CBHEs will employ the categories of practical ensembles, progressive/regressively, to focus attention upon critical aspects of each ensemble's trajectory. The result will be a chaining of progressive/regressive scenes: each scene identified by a dominant, locally applicable ensemble category.

The categories of practical ensembles, as stated earlier, refer to modes of relatedness. As such, the same collection of individuals (or role clusters) may, over time, be characterized differently - and, furthermore, may change many times. Such status changes need occur in no particular sequence. In other words, the categories assume no underlying ordinality or sequence of "stages". Thus, attention can be shifted to relevant aspects of an ensemble and its defined project at a given time. The analysis, then, is compatible with the dialectical shifts and turnabouts - wherever and whenever they occur.¹⁹

¹⁹ This means that the sampling elements need not be consistent over the course of the study. Elements of theoretical import take precedence over the consistency of sampling elements.
Method: A Study of Documents

The extended time frame of the topic under study does place restrictions upon the methodology employed. Particularly salient considerations are the availability of information throughout the time span, the comparability of that information, and the integrity of the data sources. The only viable method that can sufficiently satisfy these demands is that of a document study (see Bailey, 1978; Skocpol, 1984).

Documents as Social Productions

Although the document provides the bases for information, this investigation does not conceive of such data uncritically. Documents are seen as practical accomplishments produced by situated actors. The variability found in and of documents themselves is an indication of their "location" within particular socio-politico-economic milieu. How phenomena are documented is as important as what phenomena are documented. For this reason it is imperative that documents be seen as social productions in concrete circumstances (Foucault 1972).

Documents can be classified in various ways. For the purposes of this study, distinctions are made between primary and secondary as well as emic and etic sources.

The distinction between primary and secondary documents is a useful one (see Bailey, 1978). Primary documents are
those which characterize the social events in question by being a part of the event itself. Secondary documents, on the other hand, are removed from direct participation in the events in question. The status of a document is dependent upon how the event is framed.

Another way of classifying documents is suggested by the work of Denzin (1989). Denzin makes a distinction between emic (internal) and etic (external) accounts. Given that the units of analysis in this study are specifically defined, such a distinction by source production of documents is relatively straightforward. These categories are also consonant with the Sartrean approach discussed earlier in this chapter.

The cross-section of these classificatory schemes (i.e., primary vs. secondary and etic vs. emic) provide a framework by which documents can be located within social orders.

Primary-emic documents of the CBHEs are those which internally demarcate the ensembles' projects. They are produced by the ensemble and define the ensemble's "mission". Included in this category are organizational charters of incorporation, organizational by-laws, and amendments made to such documents. In these texts, organizing purposes and their means of implementation are abstractly outlined.
Primary-etic documents mark the impetus of important events from beyond the CBHEs themselves. Government agencies or other groups are often the concrete mediators of general political-economic social forces. These agencies often directly shape the contours of viable ensemble activity. This influence can be found in such documents (often prospectively produced) as legal statutes (e.g., session laws, revised laws, etc.), executive actions (e.g., privy council records, attorney general opinions), and judicial decisions (e.g., appellate and supreme court cases).

Secondary-emic documents are ensemble generated texts which report upon actions and events of ensembles: in effect, these are reflexive documents. Often such texts offer accounts of how the ensemble has successfully fulfilled its abstractly stated mission (see Kamakahi, 1989b). Included in this category of documents are annual reports, advertisements of services, tax returns, and miscellaneous public statements.

Finally, there are secondary-etic documents. In this category, texts are externally generated accounts of events concerning the ensembles. Most documents fall within this rubric. Government statistics gathered through its various surveillance mechanisms (see Schmitt, 1977) and newspaper articles represent important information sources (e.g., the
By employing this classification scheme, the source that generated the texts can be located or situated in the context of the events in question. Through the use of these various documents, an interpretive account of the CBHEs will be constructed.

The locating of documents within our timeframe is integral toward developing an understanding of events, modes of discourse, and the interests of parties involved. Although no complete accounting of phenomenon can be claimed, it is asserted that the matrix of information will texture a meaningful understanding of CBHE trajectories.

Outline of the Dissertation

This dissertation will be composed of eight separate chapters. A synopsis of the sequence and a brief explication of their content will now be presented.

Chapter 1 is an introduction to the study itself. Its purpose is fourfold. First, it introduces the topic of the study: the Crown-Based Health Ensembles (CBHEs). Second, the chapter discusses the theoretical orientation to be employed: an approach based upon Sartre's progressive/regressive orientation with regard to practical ensembles. Third, the methodology of documents is discussed pointing out that the sources of documentation are as
important as the content of the texts themselves. And finally, an outline to the subsequent portions of the study are presented.

Chapter 2 is entitled "The Context of Philanthropy". In this chapter an account of the development of the general socio-political-economy of Hawaii between 1800 and 1980 is presented. While this is a general account of transformation, particular emphasis will be placed upon the course of philanthropy and the specification of its prerequisites: i.e., the privatization of real property, the expansion of a money economy, and the creation of wealth-based classes.

"The Queen's Hospital" is the title of chapter 3. The creation of the Queen's Hospital was one of the most significant political and social events within Hawaii at the time: the late 1850s. This event was also surely one of the most conspicuous cooperative ventures involving the kingdom government and the private citizenry. The hospital offered Western medical care to the population at large; thus becoming, essentially, the center of socialized medicine in the Hawaiian nation. This chapter examines the trajectory of this CBHE as the hub of medical care for nearly a century and a half.

Chapter 4 is entitled "The Lunalilo Home". The advent of Westernization in Hawaii revealed itself in many ways. By the 1870s, familial dislocations were coming to the
forefront of attention. The Lunalilo Home, the philanthropic progeny of King William C. Lunalilo, turned attention toward the problem of the Native Hawaiian destitute: especially highlighting the plight of the elderly. This chapter interprets the trajectory of this CBHE as this once prominent ensemble has faded into present obscurity.

"The Kapiolani Maternity Home" is the title and the subject of chapter 5. Begun as part of an expressed concern with the apparent decimation of the numbers of Native Hawaiians, it focused upon the issue of leprosy. Leprosy, which had been the most consistent threat to the population up to that time, brought to the fore an interest in the birth process of non-leperous women of leperous parents. Later, the birthing process, women, and children would be interpreted as medical issues. This chapter chronicles the medicalization of birth in this CBHE.

Chapter 6 is entitled "The Liliuokalani Trust/Children's Center". The last monarch of Hawaii was Liliuokalani: deposed, she lived to see the land she once ruled officially become a territory of the United States. Like her predecessors, she focused her philanthropic interest upon a specific issue. In this case, the issue of concern was that of destitute orphans. This chapter reflects upon orphanism as a social problem and, later, as a medically legitimized pathos. The trajectory of orphanism and its social treatment is discussed.
Chapter 7, "The Crown-Based Health Ensembles (CBHEs)", synthesizes the information of the previous chapters, treating the Crown-Based Health Ensembles (CBHEs) panel as the topic of discussion. The chapter attempts to integrate and differentiate the various cases. It will examine the efficacy of conceiving these institutions as a panel rather than just as a set of "historical individuals" traversing a common, and sometimes shared, domain.

Chapter 8 is entitled "Discussion". In this concluding chapter, the study is summarized and issues encountered in the enterprise are restated in view of the study itself: how has the study addressed them and how might they be addressed further?; what are the implications of this study for future projects?; what has been the efficacy of the Sartrean approach?; and so on. In short, the study becomes the topic of reflexive comment.
CHAPTER 2
THE CONTEXT OF PHILANTHROPY

I treat inferiors as equals: this is a pious lie which I tell them in order to make them happy and by which it is right and proper that they be taken in, up to a certain point. ... There are poor people in this orderly world. ... The worthy poor do not realize that their function is to exercise our generosity. They are the uncomplaining poor; they hug the walls. I spring forward, I slip a small coin into their hand and, most important, I present them with a fine equalitarian smile. (Sartre, 1984: 34-5).

The concept of philanthropy represents a vortex for the discussion of socio-historical change in Hawaii and specifically of the structuring of the Crown-Based Health Ensembles (CBHEs). Each of the CBHEs was a progeny of philanthropic activities of the Crown and, at the time, the newly created political-economic arrangements of the Kingdom period. The presence of philanthropy in Hawaiian society required that fundamental aspects of traditional Native Hawaiian traditions and cultural practices be overturned. In this chapter, the implications associated with the notion of philanthropy are examined in detail.

Philanthropy: Transfer of Private Wealth

Philanthropy is generically defined in three ways: "the effort or inclination to increase the well-being of mankind, as by charitable aid or donations"; "love of
mankind in general"; and, "an action or institution designed to promote human welfare" (Morris, 1979: 984). In whatever way it is explicated, the term itself is imbued with a value connotation of virtue and/or piety. In this chapter, the term philanthropy will be used in a very restricted manner to refer to only the transfer of economic wealth from an individual to an ensemble. The oft accompanying value connotations of "for the goodwill of mankind" will be treated as socially constructed legitimations of that process (as in a vocabulary of motive) and not as an inherent aspect of the transfer of wealth itself.

Philanthropy (i.e., the transfer of private wealth from individual to ensembles) is one thread which ties the Crown-Based Health ensembles together as a panel. The existence of philanthropic activity in Hawaii's kingdom period required the realization of certain prerequisites. In essence, philanthropy could only exist in a Hawaii vastly transformed from the pre-contact, pre-kingdom era.

This chapter will be presented in the following format. First, the concept of philanthropy will be dissected and some implications of it will be presented. Second, the realization of the various aspects of philanthropy will be discussed in reference to developments which occurred during Hawaii's kingdom period. And finally, the chapter will conclude by laying out the contextual framework within which the CBHEs were created.
Dissection of Philanthropy

There has been little discussion of philanthropy and its relation to health institutions. Brown (1979) is a notable exception to the previous statement; but even he did not thoroughly examine the breadth of the concept and its relationship to the society at large. Other studies that tangentially discuss the nexus between philanthropy and health institutions include Navarro (1976) and to a much lesser degree Starr (1982).

General work on philanthropy, such as (Bremner, 1988), tends also to begin with its germination in particular cases but focuses upon the themes of humanitarianism and their relation to biographies, rather than societal prerequisites and antecedents. With regard to Hawaii, Catton (1959) briefly discusses philanthropic institutions under the rubric of social service organizations; she, however, does not provide any theoretical discussion of philanthropy or social service as a socio-political mechanism.

---

1 Brown's (1979) work in an excellent example of the influence of philanthropic enterprises and the shaping of, in his case, health education and practice. His discussion of philanthropy in that regard is exemplary; however, in discussing the social fact of philanthropy itself, Brown is not complete.

2 Humanitarianism and philanthropy are often treated in tandem a priori. For this reason works such as Bremner's (1988) tend to be of the "great man" genre. Discussion of philanthropy as a social phenomena often remains implicit, although suggesting many, if not all, of the aspects of philanthropy that will be discussed in this chapter.
Aspects of Philanthropy

In this discussion, six aspects of the concept of philanthropy will be presented. For each of these facets of the concept, there will be a brief explication of their general implications.3

First, the concept of philanthropy assumes an existent status differentiation between members of a population.4 This very general statement underlies a few auxiliary notions. It presumes that that such differentiation (which is at least horizontal, but very likely vertical as well) is associated with the asymmetric possession (or perhaps, control or mediation) of some service or product.5

Second, this differentiation in status, in the case of philanthropy, is associated with the control or mediation of

---

3 There is no assertion on my part that this is a complete denotative listing nor that the categories themselves are mutually exclusive. Again, the dissection of philanthropy is presented as a heuristic device for the purposes of discussion. It is not an ideal type in the Weberian sense because I do not propose it as a device for the comparison of cases, but rather it is used for the specification of the assumptions underlying the concept itself.

4 Note that whatever constitutes a population is a matter for philanthropists, societies, and theorists to decide.

5 Such an assumption is explicated in sociological treatments of the concept power. The assumption holds, even though power is treated in a different fashion by a variety of theorists: Weber (1946) where power is the ability to get one's way despite resistance; Parsons (1963) where power is by definition legitimized force; Emerson (1964) where power is the control of a resource of which others are dependent; and so on. Philanthropy, it might be argued, is a specific instance of power relations per se.
wealth specifically. Wealth differentiation, then, is the focus of concern. With regard to philanthropy, there must exist some process for the successive distribution of wealth: i.e., either it is transferable directly or through some formalized process. In many cases, the wealth in question is also indicative of "surplus" wealth existing in some sector of society: "surplus wealth" referring to that which is not necessary to basic sustenance. It would also be reasonable to assume that there exists a large schism between some of those that control surplus wealth and some other part of the population; otherwise, the transfer of wealth would be a rather trivial and unnoteworthy affair.

Third, there is an ideological component appended to the transfer of wealth: that of "love of mankind", humanitarianism, and so on. This legitimation of the process of wealth transfer assumes that this action is "above and beyond the call" of ordinary efforts such as the payment of taxes or the buying of commodities. In essence, the act of wealth transfer is coupled with the "great man" ideology which serves to define the philanthropist as of high

---

6 The focus upon the wealth differentiation does not mean that I assume that it is the only differentiation of import or that it is uncorrelated with other aspects of differentiation, but just the assertion that the concept of philanthropy is concerned primarily with wealth and its mediation.

7 The notion of human needs or basic sustenance is, of course, problematic.
wealth status and as a uncommonly magnanimous person.\(^8\) Concomitantly, such a process also serves as a way of legitimizing the wealth stratification system itself and the distribution through such a procedure.

While the previous aspects of philanthropy refer to the societal context, the next three refer to philanthropic activity itself. Fourth, there is an identification of a "societal need" which is being unmet by existing structures/agencies: whether traditional, cultural, societal, and so on. Now this "need" is, of course, a social construction accepted by the philanthropist and/or his agents. In some cases, the activity may in fact be the first legitimation that a "need" exists. In other cases, it may be a novel approach to some preexisting issue. It may even be a traditional approach to a traditional problem; or even a traditional approach to a new issue. Whatever the case, the philanthropist's actions link a social problem to a particular solution.

Fifth, the philanthropic act not only links a social problem to a particular solution, but also defines the target population. The target population represents part of

---

\(^8\) Philanthropists, then, have a high wealth status and the act of wealth transfer serves to raise or maintain their lofty status as generous human beings of special note. It is important to distinguish philanthropy from such ceremonies as the potlach: in which a person/family transfers "wealth", but after doing so must "start again from scratch". The philanthropist is, in essence, transferring wealth which he/she has no need of; and such an act does not destroy his wealth status in general.
the population at large. This is the group which, before the act, is disenfranchised with regard to access to (or use of) the resolution to the social problem: one previous obstacle being wealth or the availability to avail oneself to the services.

Finally, there is an ideological legitimation of the solution. The concrete establishment and use of the wealth is expected to be received by the target population with deference and gratitude. Thus, the completion of the philanthropic act is its existence in a concrete sense: at this juncture, which continues as long as the "gift" is identified, the ideological legitimation of the solution is invoked.

It can be seen that the concept of philanthropy is a complex one. The existence of philanthropy itself presumes a priori the existence of certain exigencies: wealth differentiation, the existence of surplus wealth, the identification of an unmet "need" with regard to a particular population, and so on. In the following section, the manner in which the various facets of philanthropy were instanciated in the transformation that took place during Hawaii's kingdom period will be addressed.

**Setting the Stage**

Long before the ships of Western powers first cast anchor upon Hawaiian soil, Polynesians had identified the
archipelago and some had settled upon it. Though keeping periodic contact with other Pacific island groups, the geographical locale of the archipelago fostered a form of forced trade and cultural isolationism.

By the time of western contact in Hawaii, a thriving Native Hawaiian culture existed. There existed a complex status hierarchy with numerous levels (Handy and Pukui, 1972) clumped into major strata: the ali'i, the kahuna, the konohiki, the maka'ainana, and kauwa. The ali'i were high status actors: their specific rank being determined primarily by genealogy, but also by conquest. The kahuna were a class of experts: the expertise was usually a mixture of practical skills and spiritual prowess. Medicine, dance, sorcery, and so on were the purview of kahuna. The konohiki were managers of accepted land divisions by virtue of their amicable relationship to the ali'i who oversaw the area. Because land divisions were often large, the konohiki acted as mediator and enforcer of the practical activities of social and agricultural productivity. The maka'ainana, or commoners, comprised the bulk of the population and actually worked the land and ocean for the sustenance of the society. Because foodstuffs represented the lifeblood of tribute in Hawaiian society:

9 The reason that the term Polynesian is used instead of Native Hawaiian is because there were, it is believed, several waves of migrants from ocean-faring peoples. Technically, then, the existence of a "unique" culture was not immediately established upon landing.
the notion of accumulation of wealth per se was non sequitur - i.e., food, hence wealth, was perishable. Instead, the control of status took the form of signs and pedigree as mentioned earlier.

Signs included the feather cape and helmut: which differed by length, color, type of feathers, and so forth. Also, the specification of aumakua (personal or family gods) or the selection of duty (e.g., Kamehameha's guardianship of the manifestation of a major god: Ku as Kukailimoku - a war god), offered much to the assessment of character and the interpretation of events.

The existence of the complex status hierarchy in pre-contact Hawaii, textured the manner in which stratification would occur during the kingdom period. Because only pedigree and status signs were transferable, and not wealth per se, the notion of philanthropy, as the term is used in this thesis, in ancient Hawaiian society was non-existent. The advent of the kingdom brought the ascendancy of the Kamehameha line, which itself was of low ali'i rank (see Kamakau, 1961) and concentrated the ali'i control to a small genealogical oligarchy.

Accumulation

The notion of surplus wealth for philanthropy is only a possibility when wealth or its signs (i.e., money and
products) can be accumulated and quantified. Where wealth is perishable, long term accumulation is impossible; the transfer of wealth is associated with only gains in status. In modern philanthropy, the transfer of surplus wealth does not significantly affect the high wealth status of the giver and the general low wealth status of the recipient.

In Hawaii, the creation of wealth status (i.e., accumulated material and/or signs) was created with the islands' immersion into world trade and commerce. The fact that there were systems of accumulated wealth in the foreign trading relations influenced the Hawaiian ali`i to incrementally adopt this genre. With the sandalwood industry, non-perishable goods of foreign origin could be accumulated as signs of status and wealth as well. The control of the ali`i over it was based upon his/her rights to the land upon which it grew.

Accumulation, however, on this scale was confined to a select group; and it did not, in effect, change the fact that the wealth in the Hawaiian society remained perishable foodstuffs and cultural signs.

The more diffuse control of the whaling industry which flourished in the early 19th century (1840 - 1860) spread

---

commerce and money to the port towns: specifically, Hilo, Lahaina, Wailuku, and Honolulu. These centers of commerce distributed wealth to different areas of the kingdom. The life of the ali'i, in terms of quantified wealth, was not significantly different from their pre-kingdom predecessors because there was as yet no means by which wealth could be made non-perishable. Culturally and socially, however, their worlds were much different. International trade, foreign languages and customs, and so on were diffusing through the ali'i and those that were near the port towns.

One of the most significant changes in the texture of surplus wealth, and Hawaiian society in general, was the instanciation of the Great Mahele of 1848. The Mahele of 1848 was an edict for land ownership and land adjudication among the society at large (see Chinen, 1958). In essence, the entirety of lands were wrested from the sovereign and divided into three categories: crown lands, government lands, and lands for private title. Crown lands were real properties which were to be governed by the sovereign, but were not personal property. The control of crown lands were placed in the office of the sovereign. Public lands were those real properties that were under the auspices of the government: which included legislative bodies, a judiciary, a Privy Council, and the sovereign headed each constitutionally. Kuleana, or lands available for individual titles, were awarded to those whose claims to
such lands were validated by testimony. Not just any lands could be claimed by the general population; but only those lands which one had actually labored upon. In 1850, aliens could also own property.

It is no surprise, then, that the status hierarchy just prior to the Mahele was instantly turned into a wealth hierarchy, through the ownership of land, as well. The royal families received title to extensive tracts of real property through their traditional claims of genealogical inheritance: sometimes ahupua'a (land divisions) of considerable size.\(^{11}\) Private title to real property became the most fundamental aspect, with the associated rise in a money economy, of a society wide immersion into a wealth hierarchy. All at once, one could say that there existed "surplus wealth"; property had been serialized - the community of the ahupua'a was disentangled into a network of conterminous, privately owned plots.

Individuals could now own real property; something radical, unheard of, and seemingly ridiculous from a traditional Native Hawaiian cultural viewpoint. The schism between traditional Native Hawaiian culture and the emerging post-contact society was to increase; and likewise a chasm

\(^{11}\) Ahupua'a were large land divisions which normally extended from the mountains to the ocean. In these divisions, an entire range of crops could be cultivated, and irrigation systems could be managed from their source to the area of deposit. Generally, individual families worked specific areas within an ahupua'a under the guise of the konohiki.
was developing between the maka'ainana and the elite: both alii and foreigner. The cultural legitimation of the alii was strong, but the material bind between the people and the alii was waning: Hawaii was now becoming a class society rather than a culturally stratified class-divided society.\textsuperscript{12}

The privatization of real property and the immersion of the commodity sign (money) accompanied the newly promulgated kingdom constitution and legal structures.\textsuperscript{13} These were the foundations for wealth accumulation, but such a process could not become firmly entrenched until the movement of capital through wage labor became instanciated. This process was achieved through the development of the labor intensive sugar plantations.

The emergence of the sugar plantation in Hawaii is significant for a number of reasons. First, it marked the use of a labor force renumerated primarily through wages and bound by explicit written contracts. As such, labor was explicitly distinguished from ownership. Second, the importation of foreigners as laborers altered the complexion

\textsuperscript{12} By class society, I mean that the population could be divided by their position with regard to the process of private wealth production. And, the divisions of cultural status were transferred also into that of wealth (see Giddens, 1981).

\textsuperscript{13} The Constitution of 1840 was the kingdom first such document: one which was modeled after those of western nations. Just prior to it, the first codified civil and penal codes were established.
of Hawaiian society: bringing in ethnic, cultural, and social heterogeneity. Thus, the wealth structure was eclipsing the traditional status structure as a means of identifying general social status. For example, there were financial criteria which determined whether one could run and sit in the House of Nobles. The sugar industry was the vehicle for capital movement and wealth accumulation in the Hawaiian Kingdom.

**Humanitarianism**

The influence of the west did not just come in the form of politics and economics. The western weltanschauung (i.e., world view) also exerted a tremendous influence in Hawaii.

The Protestant missionaries that were allowed to settle in the islands diffused their Calvinism through the ali`i. While the process of infiltration was disjunctive at times, missionaries were quite successful in their proselytizings especially through the creation of schools. By the time the Mahele was enacted, roughly thirty-seven percent of Hawai`i's population was Christian (see Schmitt, 1977: 35).

While the formal adoption of religion tells us little of the actual beliefs and everyday practices, it does, at the very least, serve as an indication that these people were exposed to a western weltanschauung with very definitive values and positions. Crucial disjunctures from traditional
"religious" practice would involve the notion of a monotheologic trinity, the idea of individual salvation and responsibility, and the notion that one's wealth (not cultural status) was an indicator of good favor with god.\textsuperscript{14} The influence of missionaries was not confined to the pulpit. In fact, many former missionaries, and later their offspring, would hold very influential positions in the kingdom government.

The influence of westerners, however, was not exclusively through missionary channels. Traders, whalers, politicians, merchants, and so on made their way to the islands as well. Whatever cleavages that did exist between foreigners themselves, their similarities in weltenshauung allowed for a somewhat unified influence.

The westernization of Hawaiian society was taking place on many fronts: religious, political, legal, economic, and so on. With the means of wealth accumulation instanciated after the Mahele of 1848, some legitimation of the new situation was required. Indeed, it was the notion of the "civilized" nation which buttressed the statements of the day and the days to follow.

The government now expends in the care and promotion of the health of the people at least one-tenth of the annual revenues of the Kingdom. I cannot recall to mind any other country in the

\textsuperscript{14} Weber's (1930), The Protestant Ethic and the Spirit of Capitalism, speaks to the affinity of Calvinism specifically and the notions underlying a capitalist system.
civilized world that can, in comparison, make such an unhappy statement, and yet one which is so much to the credit of the humanity of the nation. (Gibson, 1885: 12).

In relation to the health status of the population at large, a very significant concern at that, the ideology of humanitarianism prevailed. Humanitarianism meant "the belief that man's sole moral obligation is to work for the improved welfare of humanity" (Morris, 1979: 641).

The interface with civilized nations, the infiltration of the western weltanschauung emphasizing individual salvation, and the ideology of humanitarianism coalesced to act as a legitimizing milieu for the transformations in the political-economy which were taking place.

Societal "Needs"

The concretizing of the humanitarian ideal required at least three components: (1) an identified social "need"; (2) a target group or population; and (3) a means of service or treatment transfer from the source to the target.

It is essential to remember that "needs" are social constructions. The definer of "needs" is unilaterally its identifier and legitimizer. As such, the legitimation

---

15 The idea of a need is, of course, problematic. Here the term is placed within quotation marks to emphasize the subjectivity of its definition in practice. It is argued here that the "need" does not necessarily refer to any previously expressed or legitimized issue; it may, in fact, be the initial attempt at legitimizing and identifying a "concern".
of issues is filtered down through an accepted/revised lexicon; and, concomitantly, accepted ways of addressing such issues are produced.

In terms of the CBHEs, the needs and their proposed resolutions were garnered from a Western lexicon. And all four of them were attempts to address new issues in Hawaii in the manner in which they had been addressed by western nations themselves. Queen's Hospital was designed by western physicians as a means by which Hawaiians could be treated for diseases by the most modern methods of the day. Lunalilo Home was designated to address the issue of pauperism: and especially the disenfranchisement of the indigent elderly. The impetus for Kapiolani Maternity Home was the childbirthing process in light of the general decimation of the Native Hawaiian population, much of which was exacerbated by the continuing prevalence of leprosy.16 And the Liliuokalani Trust focussed upon the orphaned poor.17

16 The term leprosy is used here instead of the more palatable Hansen's disease, because the former was the term of choice in the kingdom period. Also, it almost goes without saying that the moral connotations associated with the term leprosy added much to its definition, identification, and proposed resolution.

17 I focus on the Liliuokalani Trust rather than the Liliuokalani Children's Center because the will and testrix of Liliuokalani actually proposed a solution which differed from the creation of the services actually instanciated. The legal interpretation of the original documents provided that the designated trustees could amend the particular solution that was originally proposed: an orphanage.
In each of the CBHEs, the institutional approach was accepted as the solution to a variety of social/health issues. The means was philanthropy. The target, Native Hawaiians.

**Emergence of a Westernized Hawaii**

The infiltration of western practices was not rejected wholesale by the Native Hawaiian people: many embraced Christianity, many were litigious in their western style government, and many reaped the advantages of reading the printed word - whether the bible, or newspapers, and so on (see Schmitt, 1977).

The western culture, per se, was not viewed as a demonic force. In fact, western culture was treated with great tolerance; more tolerance than westerners in general allotted to Native Hawaiian cultural practices. A more significant rupture arose over political and economic arrangements which transpired. The privatization of real property, the creation of a class society, acted as the impetus not just for tolerance of but forced acceptance of the entirety of western practices along with the legitimizing weltanshauung. Whereas previously one could select portions of the western mindset while still living in the everyday existence of the lo'i or kuleana (family/community lands) in much a traditional fashion, now, the land itself was divied, one payed taxes in cash, and to
acquire money one had to participate in trade and commerce. No one could choose to isolate themselves; all were counted and expected to participate. 18

The adoption of the wealth structure, of commodity and of exchange, meant that people could not only have little, but could, theoretically, have less than nothing (i.e., be in debt). Native Hawaiian agricultural practice, which was based on the cooperation within the ahupua'a, was virtually paralyzed when plots were separated, water rights problematic, and cash was required for taxes and exchange.

Poverty, pauperism, debt, and anomie were some outcomes of a class society in Hawaii: a society emerging with the birthing pangs of becoming a node in the world system. Waves of epidemics were brought to the islands from foreign shores: oku'u, influenza, mumps, small pox, leprosy, whooping cough, and so on. The Native Hawaiian population over the kingdom period was constantly declining. With the influx of foreign contract laborers from China, Japan, the Philippines, Puerto Rico, the Azores and so forth, Hawaii was not only becoming westernized politically and economically, but was becoming culturally heterogeneous as well.

18 The incorporation of isolated areas into the political-economic arena was rather sporadic. The trend, though, was definitely that of greater inclusion.
The Native Hawaiian aristocracy\textsuperscript{19}, and everyone else for that matter, began recognizing some of the effects of the changes that were taking place before them. The Native Hawaiians were suffering greatly from disease and, for some, this resulted in pauperism. Hawaii, during the early kingdom period, had no hospitals, care homes, and orphanages for the population at large. The royal philanthropists saw the "need", formalized the means, and sought the institutional solutions of the west.

\textbf{The Continuing Legitimation}

The consumption of the philanthropic act is not complete until the act itself is forgotten.\textsuperscript{20} This process plays itself out in the recounting of the magnanimity of the source, the re-explication of the need, and the fertility of the project itself. It is important to note that the continuing legitimation of the philanthropic act need not be isomorphic with its original pronouncements. The original

\textsuperscript{19} The royal family was a creation of the kingdom era and not isomorphic with the category alii which had existed in pre-contact Hawaii. I refer to them here as an aristocracy because there traditional cultural status was immediately transformed into a wealth status with the privitation of real property. Still the royal family represented a hereditary privileged ruling class or nobility (see Morris, 1979: 71).

\textsuperscript{20} Here I am purposefully making an analogy to George Herbert Mead's stages of the act: contact, interaction, and consummation. In philanthropy, the continuing reference to the philanthropic action is not completed while the previous stages of the act are recounted.
project is often modified in certain ways to be palatable to the existing circumstances. For example, the technical meanings of words may come into question as the exigencies of a milieu change.

For the CBHEs, the meaning of the term Hawaiian has generated some discussion (see Houston, 1939, 1950; Kamakahi, 1989a, 1989b). Does in mean those of aboriginal decent (i.e., as an ethnic category)? If so, is there a minimum "blood quantum" involved? If not, does it refer to citizenry only, or to all people that happen to find themselves within the boundaries of the islands? At any rate, the historicity of meaning and signs often comes into play.

The ongoing post-legitimation also serves to legitimize the philanthropic act in the present political-economic structures. It is little surprise that the wealth structures beyond the projects themselves are reproduced within the project. Boards of trustees, for example, are usually drawn from the wealth elite; and are selected by a process that ensures this "purity".

The philanthropic act is played out in mission statements and celebrations; enacted within the societal milieu and ensemble policy changes; and presented "as if" in pristine condition. The mission statements are, in effect,

---

21 This is a salient issue in terms of Native Hawaiian groups, the federal government, and various agencies interested in ethnicity in Hawaii. (See Kamakahi, 1990).
interpreted to the policy decisions of the ongoing ensemble (see Kamakahi, 1989c).

Discussion

The concept of philanthropy encapsulates the culmination of socio-cultural and political-economic changes that took place during Hawaii's kingdom era which spanned the 19th century. Without the privatization of real property, the adoption of a money economy, the transfer of cultural status into wealth status, and the inculcation of the notion of humanitarianism, the act of philanthropy could not exist.

These changes did occur in rapid succession during the kingdom period, and philanthropy did become a means of transferring wealth from the wealthy in the form of institutional projects for certain target populations. The CBHEs were all part and parcel of this process; all offspring of the institutional approach to health and social problems.

The Hawaii that emerged at the end of the 19th century was very different from the one that greeted that century a hundred years earlier. In 1800, the new found kingdom\(^{22}\) had little knowledge of the world beyond Polynesia. By the

\(^{22}\) The kingdom at that point included those politically aceding to Kamehameha I; which excluded Kauai and Niihau. These would become incorporated by a tributary realtion in 1810, then a royal marriage, and conquest in 1825 (Kuykendall, 1938).
end of the century, Hawaii had promulgated several
c constitutions, adopted a three branch state, privatized real
property, carried on international relations with many
nations throughout the world and had been incorporated into
the U.S. It emerged as a modern class society.
CHAPTER 3

THE QUEEN'S HOSPITAL

This surgeon claims to be a humanist and supports what has become today a basic principle for all practitioners: 'Nunquam, nisi consiente plane aegroto, amputatem suscipiant churegus'\(^1\). But this humanism thinly disguises an authoritarian paternalism: the best way to obtain the patient's consent, Achille-Cleophas advises, is to lie to him. (Sartre, 1981: 57n).

This chapter provides a progressive/regressive analysis of the Queen's Hospital: an institution which was established as the centerpiece of western medical practice in the Hawaiian Kingdom. At its inception it was the only facility in which the population at large could avail itself for medical care. The creators proposed to concentrate such expertise and social effort within this particular institution.

In this chapter, the evolution of Queen's Hospital will be examined. Of particular import in this endeavor will be the situating of this ensemble within the tumultuous political-economic milieu of Hawaii: specifically, the discontinuities which characterized Hawaiian history from the kingdom era on through early statehood. The ensemble,

\(^1\) This can be roughly translated as: "By no means, unless by mutual consent (of the patient and surgeon), undertake surgical amputation".
however, was not solely an instrument of contextual forces. Rather, it was a project continually created: being redefined by concrete actors with specific interests and particular agendas. Situating this ensemble within the parameters of political-economic events, appending groups, and the understanding of medical practice involves the discussion of philanthropic activity: specifically, in the form of the Queen Emma Trust. The thrust of the following analysis is concerned with studying Queen's Hospital as a mediation of agentic and structural influences.

**Organization: Charter of Incorporation, 1859**

With a few strokes of a pen on June 20, 1859 and the seal of the Minister of Interior, the Queen's Hospital Corporation\(^2\) (QHC) became a legal person. Until then, it was merely a social fiction whose purpose, potential, and importance were matters for public and private debate. The kingdom could proclaim it's initiation into medical modernity with the promise of this progeny. The creation of the corporation quickly elevated physicians and surgeons into a privileged status over the cornucopia of other

\(^2\) It is important to make the distinction between the Queen's Hospital Corporation and the Queen's Hospital. The former is a private legal entity which directs policy of the facility and related activities; while the latter is a particular location within which medical care was, and is, dispensed.
healers that practiced coterminaly. It was, no doubt, a
coup d'etat.

The blueprint of QHC was explicated most "legitimately" in the charter of incorporation. The charter refers to both the document filed with the kingdom government as well as the government's granting the corporation the rights to conduct business within the jurisdiction with limited liability (see Hamilton, 1987).

In the charter's text, the corporation judiciously designated the sovereigns, King Alexander Liholiho (Kamehameha IV) and Queen Emma, as royal patrons. In addition, the King was elected, then declared, perpetual president of the corporation. Throughout the Kingdom era, the sovereign would officially be president of the corporation. Previous discussion had settled upon the hospital corporation itself to be named in honor of Her Majesty the Queen.

Twenty trustees were named: ten by subscribers to the corporation and ten "on behalf of the government". The ten subscribers' trustees were: B.F. Snow, Samuel C. Damon, Samuel N. Castle, Charles R. Bishop, J.W. Austin, Edwin O. Hall, John T. Waterhouse, W.A. Aldrich, William L. Green, and H. Hackfield. The ten government trustees, nominated by the Minister of the Interior, were: Prince Lot Kamehameha, David L. Gregg, William Webster, George M. Robertson, T.C.

The board of trustees was empowered with the management of corporate policy. The initial outline of this involved the demarcation of authority and its rules of succession. The quasi-public nature of the alliance prospectively offered no foreseeable complications. It must be emphasized that the corporation was a private legal entity, although its existence was overwhelmingly dependent upon the coffers and policies of the Kingdom government.

As for the corporation's mission, the charter states that the corporation was established "for the relief of indigent sick and disabled Hawaiians, as well as of such foreigners and others as may desire to avail themselves of the same" (Queen's Hospital, 1859: 2). The explicitness of the target population, the indigent sick and disabled, meant that anyone, regardless of means, was now entitled to medical care. Medical care, then, had become an inalienable right and not just a privilege of the Native Hawaiian population.

As with any document, the charter was imbued with the implicit understandings of the day. While such understandings were unambiguous in 1859, later they would be subject to reinterpretation and "clarification". Three major issues of such "clarification" would arise in subsequent years with regard to the hospital's mission: to
whom did the term "Hawaiians" refer specifically; to what extent was there an obligation regarding the corporation to offer free medical care to sick indigents; and what were the limits of discretionary treatment with regard to fees that the ensemble could provide. These issues will be discussed in detail later in the chapter as they represent complications which arose with the change of political-economic and socio-cultural milieu. Within the context of Hawaii in 1859, these issues were beyond the horizon of problematic contemplation.

Under the seal of the Minister of the Interior, Prince Lot Kamehameha, the perpetual charter for the Queen's Hospital Corporation was enacted: the 20th day of June in 1859.

**The Sovereigns**

The acceptance of western medical practice for the sovereigns was hardly an earth-shattering transformation. Both the King and Queen had been acclimated to such care through education and experience. Their respective cultural statuses as alii afforded them ample opportunities for understanding the western weltanschauung. And their subsequent appointments as royal patrons was in recognition of their fund raising and lobbying efforts in establishing the hospital.
Alexander Liholiho was the son of Mataio Kekuanaoa and Kinau. His maternal grandfather was Kamehameha I: the uniter and first king of the island archipelago. As youngsters both Alexander and his elder brother, Lot Kapuaiwa Kamehameha, had attended the Chiefs' Children School. Later, as part of their education, the young princes accompanied Dr. Gerrit Judd\(^3\) as secretaries in travels to the United States, Great Britain, and France. While still a teenager, the then prince was familiar with medical techniques such as bleeding and had personally undergone successful western medical treatment by Sir James Clark while in London; Clark was the personal physician to Queen Victoria (Adler, 1967). During this voyage, which took place in 1849-1850, he was able to observe, first-hand, various types of western institutions including hospitals, prisons, and "lunatic" asylums (p.97). Thus, even before becoming king, Alexander Liholiho was acquainted with western medical care and institutional "solutions" to social problems.

Emma Kalanikaumakeamano\(^4\) was the daughter of George Naea and Fanny Kakelaokalani Young. She was a granddaughter of John Young, trusted English advisor to Kamehameha I, and

---

\(^3\) Dr. Judd was a physician that served in very influential posts in the kingdom government.

\(^4\) She would later take the name Kaleleonalani, for which she is better known, after the death of her husband and son.
great-granddaughter of Kelamaikai, a full brother of Kamehameha I. As a child she was adopted by her aunt, Grace Kamaikiui Young, and uncle, Dr. Thomas C.B. Rooke, an English physician. Like her husband, Emma had attended the Chiefs' Childrens School and "later had an English governess, receiving an excellent education in western ways" (Day, 1984: 39). Her adopted father, Dr. Rooke, had run a private dispensary, served as a government physician during the smallpox epidemic of 1853, and was personal physician to Kamehameha III (King, 1982: 148). The queen, then, was also well exposed to the western weltanschauung, including that of medical care.

Through these ali'i, we see a template for the future. The world had been opened up to them; a world beyond traditional Native Hawaiian horizons. Unlike previous sovereigns who were exposed to western culture ex post facto, Alexander Liholiho and Emma were inculcated with it in varying degrees in their existential experiences. They recognized Hawaii as a little nation among giants: an acorn among trees. They also were cognizant that the population was declining because of the introduction of foreign diseases that traditional practices were impotent in treating.\(^5\) It is, then, of little surprise that during

\(^5\) Western practices and practitioners were equally as ineffectual with regard to these diseases. Western countries as well were suffering from the same epidemics (see Rosenberg, 1962).
their reign the notion of creating a medical institution comes to the fore: extending care previously available to a selected few to the populous.

**Subscribers' Trustees**

Prior to formalizing the charter itself, a series of preliminary meeting of private citizens interested in establishing a hospital corporation in Honolulu had been held. In these gatherings, the skeleton of the projected organization was discussed and debated.

Some parameters were circumscribed by explicit political-economic contingencies. Of particular import was "An Act to Provide Hospitals for the Relief of Hawaiians in the City of Honolulu and other Localities" enacted by the Kingdom legislature in 1859. The act was the basic template upon which the Queen's Hospital Corporation was molded. But there were other motivations for its creation including, among other considerations, the demonstration of the superiority of western over Native Hawaiian health practices (and cultural practices in general), the civilization/enlightenment of the island kingdom, the increasing efforts to organize physicians and surgeons as a profession, and, of course, the genuine concern with the devastating effects of diseases on the Native Hawaiian population.
In accord with the Hospital Act, subscriptions toward the creation of a hospital corporation were proceeding. Periodically, names of subscribers were reported in the newspapers and their praiseworthiness expressed. The act of subscription, however, assumed two exigencies of donors: (1) that contributors were among those situated within the money economy, and (2) that subscriptions were, in essence, excess funds. Few people within the kingdom met these two (implicit) criteria. Those that could participate were predominantly of foreign origin.

In fact, all ten of the subscribers' trustees were of foreign birth and were involved in island commerce. Five were engaged in either merchantile or investment firms: S.N. Castle, C.R. Bishop, E.O. Hall, J.T. Waterhouse, and H. Hackfield. Four of the trustees were associated in some way with transportation, specifically with steamships lines: B.F. Snow, J.W. Austin, W.L. Green, and W.A. Aldrich. S.C. Damon published the Friend; and E.O. Hall, mentioned earlier, published the Polynesian: two prominent newspapers of the day. And three of the ten were among the protestant missionaries who settled in Honolulu in 1820: S.N. Castle, S.C. Damon, and E.O. Hall. Needless to say, the subscribers' trustees were a Who's Who of private enterprise in 1859 Hawaii.

As trustees, they were elected from a body of other like-minded subscribers, and held the torch for the
interests of the western Weltanschauung in general and of the interests of trade and commerce in particular.

**Government Trustees**

Unlike the subscribers' trustees, those appointed "on behalf of the government" were not as deeply entrenched in commerce per se. Not surprisingly, though, nine of the ten were of foreign birth. The only exception was Prince Lot, the King's elder brother as well as the Minister of the Interior.

Prince Lot, who would later succeed his brother as King Kamehameha V, had accompanied Dr. Judd and Alexander Liholiho during the 1849-1850 foreign voyages. As such, he had had the same exposure to western institutions and asylums, education, and medical practice as had his brother. As Minister of the Interior, Lot was not only to approve the government trustees, but also to validate the perpetual charter of incorporation. The Prince's role then, although not conspicuous, was pivotal for the corporation's establishment.

Among those sitting on the board of trustees were D.L. Gregg, the Minister of Finance, a Catholic and former U.S. Commissioner, and Lot, the Minister of the Interior. William Webster, an engineer by trade, sat on the privy council; he had been in charge of harbor improvements. A.B. Bates, Dr. Judd's brother-in-law, was a government attorney.
J. Montgomery had been associated with the British General Counsel and had a specific interest in the hospital. G.M. Robertson was an Associate Justice on the Kingdom's Supreme Court. And T.C. Heuck was to be the architect of Queen's Hospital.⁶

The explicit incorporation of governmental trustees into the corporate structure testifies to the government's importance for the viability of the project itself. Through legislative actions, in executive sponsorship, and in grants and appropriations, the government set conspicuous parameters and directions for the Queen's Hospital Corporation. Although the creation of government trustees was an implicit acknowledgement to the corporation's dependency on the State apparatus; the charter itself had only to address the activities of the private corporation per se. The appointment of government officials to private corporations in the 19th century was a common practice: it's intent being that such persons would act as agents for the public interest.

**The Quasi-Public Institution**

The signing of the charter for the Queen's Hospital Corporation marked a unique arrangement between the private and public sectors. The arrangement called for private

---

⁶ Pertinent information of the three other trustees (namely, J. Ladd, J. Bissett, and H.J.H. Holdsworth) was not attained for the period surrounding 1859.
citizens to subscribe to the fund toward building the hospital. Once a particular amount of money was raised, the government would then provide a parcel of land and certain appropriations for the hospital's continued maintenance. The merger of subscribers' and governmental appointees on the board of trustees solidified this tenuous arrangement. Queen's Hospital Corporation was intended to be one of several entities, one on each island, created for the expressed purpose of providing medical care to the indigent sick. But it was the only one to come to fruition. As a result, the hospital became increasingly perceived as the center of socialized medical practice as well as the proposed site for medical training in the Kingdom. Queen's Hospital, at the time, was envisioned as the hub around which medical care in the islands would revolve.

**Seriality: Before the Conception, pre-1854**

The availability of western medical care prior to 1854 was scant. And it is likely that the desire for it among the Native Hawaiian populous was scanty still. For although the Native Hawaiian population had been decreasing in numbers, the vast majority of these people had little knowledge of and little access to such treatment.

In the decades before the establishment of Queen's Hospital, waves of epidemics had bombarded the scattered populations of the archipelago. Influenza, mumps, measles,
whooping cough, smallpox, and other assorted diseases wreaked havoc upon island populations not to mention the discordant influences they exerted upon native cultural practices. And yet, we find that the hospitals and medical treatment in existence at the time were not intended for nor did they imagine serving the Native Hawaiian population at large. On the contrary, such facilities were designated for specific groups of westerners.

Western Contact

Western exploration in the Pacific was expanding in the late 18th and early 19th centuries. In 1778, the ship Resolution under the command of Captain James Cook sighted the northwestern islands of the archipelago. In ethnocentric manner he christened them the Sandwich Isles in honor of a patron half way across the globe.

The natives, of course, had settled upon the islands much earlier. The distant waves of separate Pacific ocean farers' migrations to the islands had precipitated the development of a distinct culture forged from the template of Polynesia. The Native Hawaiian language was similar to that of islands familiar to the Westerners: facilitating communication ergo fostering trade.

In fact it was not long before Hawaii, now a fledgling kingdom, entered the arena of world commerce and trade. The raw material of interest was 'iliahi: known throughout the
western world as sandalwood. The fragrant wood was exported mainly upon American vessels bound for China. And because of its decimation in other parts of the world, Hawaii became the chief source of this product to China during the first few decades of the 19th century (Schmitt, 1977: 368).

As the sandalwood in forests were in the process of being decimated by aggressive exploitation, the appearance of a whaling industry was on the horizon. Whaling ships began to frequent Hawaiian ports. The whaling industry quickly became dominant; a dominance which stretched from the 1830s to the 1850s (Kuykendall, 1938).

In both the sandalwood trade and whaling industry, the islands primarily offered natural resources and geographical convenience. In the former case, forests needed only to be surveyed, trees to be felled, and cargo to be prepared and loaded aboard ship. In the latter, Hawaii's geography and ability to supply food and drink were all that were necessary. Though Hawaii was a supplier of raw materials, it produced (i.e., manufactured) nothing. What these activities did foster was the development of port towns: places where ships could moor close to shore. Honolulu on Oahu, Hilo on Hawaii, and Lahaina on Maui served such purposes quite well. Lahaina, in fact, served as the main gathering place for whalers and as the kingdom's capital from 1820 to 1845 (Pukui et al, 1974: 127).
While these places became centers of trade in the islands, the bulk of the kingdom's population remained in other areas. Between 1820 and 1853, only 26.4% and 32.8% of the kingdom population respectively lived in the port towns (see Schmitt, 1977). The importance of these areas was not in population concentration but rather in terms of the politicization and commodification of space; and concomitantly in the form of the infiltration of foreign influence.\(^7\)

Other changes were taking place. American missionaries of the Calvinist persuasion had gained access to the Native Hawaiian population since 1820. The protestant ethic was exercised with ardent fervor\(^8\); cultural genocide was, no doubt, its goal. The tools the missionaries brought with them were single-mindedness of purpose, knowledge of the outside world, and literacy. Coalescing religious belief with education and proselyzation with knowledge was a very successful strategy.

\(^7\) The work of Giddens (1981) posits the commodification of space and time to be associated with the ability of surveillance. The western influence in Hawaii overlaid new aspects of surveillance upon that already existing in Native Hawaiian culture having particular repercussion in the division of "rights".

\(^8\) The missions into Hawaii were predominantly Calvinist. The work of Weber (1946) may be particularly relevant here as a backdrop to the infiltration and diffusion of particular value/behavioral orientations: particularly affecting the royal family.
By 1853, a mere 23 years since the first missionaries' arrival in Hawaii, roughly 80% of the kingdom population was Protestant: and virtually all others in the kingdom were affiliated with the Roman Catholics or Mormons (see Schmitt, 1977: 35). Just as impressive was the estimate that the literacy rate of the population of some 72,000 was an astounding 75% (Schmitt, 1977): among the best in the entire world!

The kingdom, since 1840, was formally a constitutional monarchy possessing a bicameral legislature, a judicial system, and an executive branch modelled after that of western nations. It was an arrangement of checks and balances which disaggregated the divine right of kings. The Native Hawaiians were a very politically active and litigious people. Perhaps the discourse of tradition and the relative stability of everyday life was sufficient in the quelching of political demurs.

In the Great Mahele of 1848, a kingdom-wide land adjudication process to oversee and assign private ownership of real property was begun. Cultural status had been transformed into political-economic status as well for select groups: the most privileged being the royal families. But the consequences of these changes were not recognized immediately. Later, however, the privatization of real property would have extensive effects in the disintegration of community systems.
Historian Ralph Kuykendall (1938) referred to the era between 1778 and 1854 as that of "foundation and transformation". The transformations were indeed drastic: touching upon virtually every aspect of Native Hawaiian life and culture. The historical metamorphoses are reflected in the events which took place in the sphere of health and health practices.

Health, Illness, and Treatment in the Early Kingdom Era

There is great variability regarding the estimates of pre-contact and post-contact populations in Hawaii (see Stannard, 1989; Schmitt, 1977). But even the most conservative of estimates acknowledges a marked decline in numbers over time. The impetus for this depopulation lies in the introduction of foreign diseases into Hawaii interacting with the interleaven contact among Native Hawaiians themselves.

Epidemic mortality by such afflictions as "okuu", believed to be either cholera or bubonic plague (Kuykendall, 1938), influenza, measles, and so on mounted as vectors raged throughout populations of the islands. Uncounted others would have laid prostrate or at least been temporarily unable to sustain mundane practices due to morbidity and/or caregiving for the sick. There is little doubt that by the 1850s the population was less than half of what it had been just five decades earlier.
For both native and western healers, there was little to be done. There was only comfort to be given. Western countries at this time were little better off as they also suffered from epidemics of the same afflictions; it was "God's will" (see Rosenberg, 1962). The sad truth was that people, and communities, died and there was nothing to be done about it.

During this tragic period, western medicine was as divinely inspired as was Native Hawaiian health practice: and probably more so. The kahuna lapaau underwent an extensive apprenticeship regarding the relationship between specific herbs and concocted preparations in the treatment of particular ailments. While native etiology was more mystical, its treatment was more precise and instrumental (even though couched in the context of mystical rites). Nevertheless, the western diseases were beyond the purview of indigenous health practices.

Western physicians, though medically ineffective, none-the-less were received with much deference. This was probably due as much to their knowledge of foreign affairs and as men of letters than for medical prowess per se. For example, Don Francisco de Paula Marin, though probably not a physician by training, enjoyed much influence with Kamehameha I while also attending to the king's physical health (Gast and Conrad, 1973).
The first wave of "true" physicians were those which were consigned to missionary groups, although there were physicians which had been aboard British whaling vessels and various other ships. In the Kailua mission in Kona, Hawaii's first resident physician, Dr. Thomas Holman arrived in 1820. The Honolulu mission, the largest missionary effort, brought with it Dr. Abraham Blatchley in 1823 and Dr. Geritt P. Judd five years later. Dr. Judd, of course, would be influential in kingdom politics as advisor and office holder under Kamehameha III and as overseer to the two young princes, Alexander Liholiho and Lot Kamehameha. Dr. Dwight Baldwin and Dr. Alonzo Chapin were among members of the Lahaina mission established in 1823. And on the isle of Kauai, in Koloa, the missionary physicians included were Dr. James W. Smith and Dr. Thomas Lafon.

Other physicians not affiliated with the missionary missions arrived in the islands as well. Two early arrivals were Drs. Rooke and Wood. Dr. Thomas C.B. Rooke, who would later be the adoptive father of Queen Emma, was of British descent and arrived in Lahaina aboard a whaling vessel circa 1829. Dr. Robert Wood arrived from the east coast of America in 1839. Among physicians arriving in the islands just prior to serious discussion about a "public" hospital were Dr. Edward Hoffman, Dr. Seth Porter Ford, and Dr. William Hillebrand. Dr. Seth Ford would found a hospital in Nuuanu Valley in 1852 with Dr. George Lathrop; and Ford
established City Hospital in 1853 with Dr. Charles Guillou. And Dr. Hillebrand would be selected as the first chief physician for the Queen's hospital.

In general, physicians and surgeons were few and far between in the islands. Schmitt (1977: 66) reports the following number of physicians and surgeons for selected years: 1 in 1820; 2 in 1830; 6 in 1840; and 17 in 1853.

**Hospitals: 1800 - 1854**

As western expansion into the Pacific began to encompass Hawaii, the western weltanschauung and practices began to infiltrate Native Hawaiian socio-cultural practice.

In terms of health practices, the western powers were spreading their influence. The United States, for example, enacted the Merchant Marines Service Act of 1789. This piece of legislation provided free health services to U.S. seamen as well as enabling for the construction and maintenance of hospitals in selected port cities (see Kronenfeld and Whicker, 1984). Apparently, France and Great Britain had enacted similar legislation for all three of these Western powers would establish seamen's hospitals upon Hawaiian shores.

In all, five such hospitals were established and operated: three in Honolulu on Oahu; one in Hilo on Hawaii; and one in Lahaina on Maui. They were all established between the late 1830s and the early 1850s. The treatment
in such institutions was crude and largely palliative. Few details are known of these facilities, but the newspapers of the day were hardly praiseworthy of them. The following quotation concerns the British hospital of 1833.

"... the hovel they [the British Seamen] were lodged in being scarcely more than shelter from the rays of the sun - but really, hardly any from rain or wind, without any conveniences or comforts necessary for invalids". (The Polynesian, 1840: 74).

The U.S. Seaman's hospital of 1837 is described in a much better light than its British counterpart.

A convenient establishment, at Waikiki, has been rented by the U.S. Consul, for the past year, for the accommodation of the seamen upon his hands ... the situation of the sick has been more comfortable than it was, when they were quartered in a grog shop, in the town, as was formerly the case. (Hawaiian Spectator, 1838: 86-89).

Between 1839 and 1844, the U.S. Seaman's hospital in Honolulu treated some 266 patients of which only 10 had died (Schmitt, 1956). The success of the hospital care had probably more to do with the mildness of the afflictions than with the precise instrumentality of the care. The seamen's hospitals, after all, were "designed" for convalescence and there was little social control either on the part of physicians and/or the encompassing foreign government with regard to their operation (Schmitt, 1956; Kamakahi, n.d.).
These glimpses of the hospitals make two things clear. First, what passes for a hospital and acceptable health practice at any given time may not adhere to the requirements at another time or in another context (Kamakahi, 1989a). And secondly, that discourse is colored by the horizons of the epoche and the interests of the medium. Although not conspicuously displayed, the publishers and the press in general during this period was the product of American foreigners with clearly delineated interests in the United States' annexation of the islands (see Kuykendall, 1938, 1953; King, 1982).

City Hospital was the only private venture of note prior to the discussion of hospital expansion. Founded by Dr. Seth Porter Ford and Dr. Charles Guillou in 1853, the advertisements for the facility touted it as the "first true civilian general hospital in the islands". Dr. Edward Hoffman was an attending physician of the facility. While it was the case that City Hospital was the first civilian hospital in the islands, it was also the case that treatment was strictly fee-for-service. This criteria essentially limited its clientel to foreigners residing in the islands (including denizens and naturalized citizens) and the Native Hawaiian bourgeoisie.

---

9 Of relevance here would be the various works of the Frankfurt School and of "Post-modernists" such as Foucault, Baudrillard, and so on.
It can be seen that even though Hawaii had undergone tremendous political-economic transformations, the effects were limited geo-politically and were not translated into the fundamental exigencies of everyday existence of the non-port populations. Though western diseases had had far-reaching effects, western treatment was largely impotent and inconspicuous. The kingdom had promulgated laws, signed treaties, and adopted the surface features of the west. But, the changes in infra-structure, the core of any society, were yet to transpire.

Groups-in-fusion: A Hospital, 1855 - 1859

On the 15th of December in 1854 Alexander Liholiho ascended to the throne following his uncle, Kauikeauoli (Kamehameha III), as ruling sovereign. Kauikeauoli had instanciated the facade of the west: creating civil codes, penal codes, a constitution, treaties with foreign countries, and privatized the ownership of real property. But it would be Alexander Liholiho and, later, Lot Kamehameha who would create the all important infrastructure of western society in Hawaii. Their predecessor had created the project, but it would be they who were to breath life into it. It was not long until this new sovereign, Alexander Liholiho, participated in bringing the idea of a public hospital to the fore.
Act I

Just six months after ascending to the throne, Alexander Liholiho (Kamehameha IV) affixed his signature to a bill entitled "An Act To Institute Hospitals For The Sick Poor". The act reads, in part, as follows:

Whereas past experience and daily repeated observation show the necessity and duty of the public to provide Hospitals for their relief, where they may receive kind nursing and skillful attendance; and that the said Hospitals may become schools where a certain number of intelligent Hawaiians selected for the object, may be instructed in medical sciences and the cure of the numerous diseases now prevalent and that are constantly on the increase .... (Kingdom of Hawaii, 1885: 20).

The act itself calls for the establishment of two hospitals for the sick poor, "one at Honolulu, Island of Oahu, and one at Lahaina, Island of Maui". The Minister of the Interior, at his discretion, was given the authority to establish hospitals under the same template for the islands of Hawaii and Kauai. These facilities were to be under the supervision of the Board of Health and the respective island governors.

In this text, we find a number of assertions both explicit and implicit. First, it eludes to the depopulation among the kingdom's peoples and attributes this to various diseases which have afflicted the islands. Second, it singles out medical science as the means by which such affictions can be treated (and cured). Third, we see the
hospital, an institutional method for addressing health problems, being specified as appropriate. Fourth, there is a recognition that such services are "needed". And it indicates that the hospitals were to serve multiple purposes: treatment of the sick, as a place for medical education, and, perhaps most importantly, as an example of public (i.e., governmental) responsibility in action.

Lacking any tradition in the institutional approach to defining and treating health problems, the idea of a public hospital was indeed a novel one in this context. But with the influence of those of foreign origins and the amenability of the king who had seen such facilities in his earlier travels, the project was encouraged.

The idea and the motivations, however, were insufficient in creating tangible movement on the act. While mention of the hospital was occasionally discussed in the tabloids of the day, no conspicuous activity was forthcoming. Assorted entries of David Gregg, Minister of Finance, suggest, however, that there was some serendipitous behind-the-scenes negotiations and posturing regarding a prospective hospital (King, 1982).

**Act II**

It was not until April of 1859, that we see explicit evidence of interests in a hospital coming to a head. In "An Act to Provide for the Relief of Hawaiians in the City
of Honolulu and Other Localities", there is the overt attempt to create hospitals under the rubric of special franchises rather than as public institutions per se.

Section one of the act reads as follows:

> It shall be competent for the Minister of the Interior under the regulations prescribed by the general law in regard to Corporations, to grant a perpetual charter to any of the inhabitants of the city of Honolulu applying for the same, being subjects or denizens of the kingdom, and to their successors, for the establishment of a hospital in said city, or the vicinity thereof, for the relief of sick and destitute Hawaiians. (Kingdom of Hawaii, 1859: 433).

The act called for the corporation to raise five thousand dollars. At such time, the government, through special franchise, would donate property of equivalent value to the corporation. The Supreme Court would then be entitled to "exercise a general supervision over the corporation". The act also provided for the establishment of one hospital on each of the islands of Maui, Hawaii, and Kauai; these proposed corporations would only have to raise twenty-five hundred dollars for an equivalent value special franchise from the government.

Although this act of 1859 is forged from that of 1855, there are some definite differences between the two.

First, the projected public hospital was transformed into a quasi-public one. In 1855, the Board of Health and respective island governors were to oversee the hospitals. In 1859, it is the Supreme Court which is given such duties.
The hospital would no longer be a child of the State, but rather a private corporation which the State facilitates, legitimizes, and nurtures. The government provided the template and the franchise; but it is the corporation which was responsible for the policy and activities of the hospital.

Second, the act of 1859 focuses attention only upon the city of Honolulu. In the previous piece of legislation, two cities (i.e., Honolulu and Lahaina) were specified. In may be important to note Honolulu was now the center of business and commerce in Hawaii; and Lahaina's importance and that of the whaling industry were waning.

Third, the 1859 act displays the dominance of Honolulu in that it is expected that the corporation would be able to raise twice the funds of other islands and therefore receive twice the land grant from the government as well. One could, by implication, posit that the Honolulu hospital was to be the center of medical care in the islands. Geopolitical influence was in Honolulu; and so was the money. In fact it was quite doubtful at the time that the outer islands could raise funds to the tune of $2500; none did.

The Queen's Hospital Corporation was the only hospital to be incorporated under this act of legislation. The corporation was able to do so in two short months. The act was amended as it pertained to the city of Honolulu "containing a provision with specific reference to the
Queen's Hospital" which had satisfied the requirements for the island of Oahu (Territory of Hawaii, 1905: 1291).

The granting of the charter of incorporation legitimized the structural relations existing between the private sector of trade and commerce on the one hand and the kingdom government on the other. One could not speak of commerce without capital and one could not refer to public policy without economic infrastructure. One had to, in essence, speak of a political-economy of intimate mutual dependency.

Fund Raising

It was not long before actual fund raising activities were taking place. The efforts of both sovereigns were conspicuously mentioned in the press.

It is well known in this community that Her Majesty Queen Emma has long entertained the project of collecting subscriptions for a Hospital for sick and indigent Hawaiians. ... For two or three days past his Majesty [Alexander Liholiho] has been seen in the most frequented parts of town with his memorandum book in hand, soliciting subscriptions to a Hospital for his poorest subjects. ... Hitherto a large number of persons remain unsolicited, but they may rest assured that the King will fall in with them in good time. (The Polynesian, 1859a: 2).

In fact the raising of funds for the hospital moved along quite swiftly. The target of five thousand dollars was surpassed to the amount of $13,150.73 to which the kingdom legislature appended another $6,000 (Honolulu
Advertiser, 1959). The contribution of the legislature was independent of that of the special franchise specified in their act of 1859.

This extra legislative appropriation was one of the main foci of Alexander Liholiho's speech proroguing the 1859 legislature: for it occurred at a time when the government coffers were low but interest in the hospital was at a peak.

I confess that the act of your two Houses which I regard with most complacency, is that in which you commit the public Treasury to the aid of Hospitals. You, Representatives, amongst whose constituents are those very persons for whom these places of refuge are principally designed, have expressed a kind and grateful feeling for the personal share which I and the Queen have taken in labor of securing the necessary means for the establishment of a Hospital in Honolulu. Whilst acknowledging your courtesy I wish to take this first public occasion to express the almost unspeakable satisfaction with which I have found my efforts successful beyond my hopes. It is due to the subscribers as a body, that I should bear witness to the readiness, not less than the liberality, with which they have met my advances. When you return to your several places, let the fact be made known, that in Honolulu the sick man has a friend in everybody. Nor do I believe that He who made us all, and to whose keeping I commend in now dismissing you, has seen with indifference how the claims of a common humanity have drawn together, in the subscription list, names representative of almost every race of men under the sun. (The Polynesian, 1859b: 2).

Institutionalization: Queen's Hospital, 1859 - 1899

Once the charter of Queen's Hospital Corporation had been duly processed, what existed was a legal entity and a social promise. The corporation was not yet a hospital, only the projection of one on the horizon. In the period
between 1859 and 1899, the corporation was to create its niche in the fabric of Hawaiian society.

Building Infrastructure

The period between 1859 and 1899 saw tremendous changes take place in Hawaii. The building of infrastructure would characterize the period. Five sovereigns would oversee the rise of institutional approaches to defining and addressing problems. But it would be through the laws of corporations in consanguinity with State policy that would spread geopolitical control from the port towns and Honolulu to also encompass the farther recesses of the population.

The building of infrastructure (e.g., hospitals, roads, railroads, schools, etc.) was to become of utmost import. The kingdom, after all, seemed intent on becoming a debutante in an established world order.

Both the sandalwood trade and the whaling industry were on their last legs. As had happened elsewhere in the world, the sandalwood trees were essentially no more: extinguishing that means of trade and commerce. Whaling, having reach its peak in the 1850s, declined more rapidly than it had arisen.

Agriculture, however, became the focus of a renewed intensity. Agriculture on a large scale, the plantation, was being experimented with. Such enterprises were labor intensive. The kingdom population was still on the decrease, the kingdom's coffers low, and diseases still
being introduced and re-introduced with alarming frequency, the potential domestic work force would be seen as inadequate for plantation agriculture. The solution, it was decided, was the importation of contract laborers from abroad.

With this influx of "new" foreigners, diseases would this time come from the East as well as the West. As immigrant contract laborers came to work the sugar plantations, they brought with them their language, culture, and ailments. Scarlet fever, whooping cough, measles, dysentery, cholera, and bubonic plague would make their appearances (Schmitt, 1977: 59).

In the realm of government, the strength of the Crown was to wane against the forces of commerce and annexation. In turn the brothers, Alexander Liholiho and Lot Kamehameha, would reign. Then there would be the elected monarchs of William C. Lunalilo followed by David Kalakaua. The only female monarch, Liliuokalani, would inherit a troubled kingdom and would live to see it dissolved. The rebel government and the Republic of Hawaii would live out the century.

Health Ensembles: 1860 – 1899

Between 1860 and 1899, the government would create institutions to deal with social and health problems. The already existent Board of Health would be the foundation of
these enterprises in the realm of health/medical practice. The bulk of such activity would still be focused in and around Honolulu: the Hawaiian nation's geo-political center.

The State created three purely public health institutions during this period: Kalihi Hospital, the Kalaupapa Settlement Hospital, and the Oahu Insane Asylum. The Kalihi and Kalaupapa facilities were attempts to contain what was referred to as ma'i pake (lit. Chinese disease): more notoriously known as leprosy. The Kalihi facility was used as a temporary station for the observation of the condition's severity. If the person was designated as a leper, he/she was sent to the settlement of Kalawao on the isolated Kalaupapa peninsula on the island of Molokai for what amounted to a life sentence.

The Oahu Insane Asylum in the realm of mental health was an institution set aside for those unable to care for themselves: i.e., to remove the feeble-minded from the prisons within which they were and would be housed (see Talmadge, 1989). Just as the lexicon of western physical health had been adopted in the case of hospitals, the definitions of western mental health from far off continents were instanciated in the asylum. All three of these institutions were established in the biennium period 1865 to 1866.

The next wave of hospitals to be created were associated with the corporate plantations. On Oahu five
such facilities were established between 1890 and 1898; on
Hawaii, one founded in the district of Hamakua; and on
Kauai, seven were dispersed around the island. In all,
there were approximately thirteen plantation hospitals in
existence by the turn of the century. The care meted out in
these facilities was variable and largely unsupervised. For
the most part, physicians served a dual role as medical
authority and plantation watchdog.

In administering medical care to plantation
laborers, the doctor was expected to ferret out and
punish malingerers. He could declare that a worker
claiming to be ill was fit and fine him $3 for the
first offense and $9 for subsequent offenses. He
could also use his hospital as a "jail". (Takaki,
1983: 100).

The plantation hospitals were designed for segregated
populations of contract laborers. They were rural,
corporate, and crude.

While the state of medical practice had not improved
appreciably over the past half century, the organization of
western health practitioners was apparent. The Hawaii
Medical Association had been founded in 1856 as an
organization for practicing physicians and surgeons. And,
in the forty years since the founding of Queen's Hospital,
the number of physicians and surgeons had increased from
about twenty to the seventy-six reported in 1897 (Schmitt,
The institutional approach to health and illness in the kingdom emulated that already established in the west (see Rothman, 1971; Starr, 1982). With such arrangements, social control within institutions by staff as well as social control of institutions by encompassing surveillent agencies was facilitated (Kamakahi, n.d.). At the very least, the enumeration and description of illness and various treatments could be accumulated and recorded on a systematic basis (see Foucault, 1973; Giddens, 1981).

Queen's Hospital, 1859 - 1899

In July of 1860, "An Act in Aid of the Queen's Hospital Corporation" was signed by Alexander Liholiho. It basically repealed the act of 1859 under which the corporation was chartered as it concerned the city of Honolulu. A plot of land at the base of Punchbowl crater and the sum of $5000 was granted to the hospital from the government.

The cornerstone for the building was laid in that very month, and by the end of the year the buildings designed by trustee T.C. Heuck were in place.

The Pacific Commercial Advertiser, a newspaper of the day, published the following account.

Perhaps the best evidence of the present civilized condition of the Hawaiian nation is that structure just completed, which stands at the foot of Punchbowl Hill, and is known as the Queen's Hospital. Under any circumstances, the erection of such a building in any country would indicate the existence of the highest order of Christian
benevolence towards the destitute sick, who are unable to provide their food and clothing, much less to obtain the medical assistance and care necessary to restore health and prolong life or alleviate the sufferings inseparable from the last hours of dying humanity. ... the plan of erecting a general hospital originated in the heart of our noble Queen, who herself received these philanthropic impulses from her generous adopted father, the late Dr. Rooke ... (Pacific Commercial Advertiser, 1860: 2).\textsuperscript{10}

Greer (1969) notes that the buildings of the hospital itself "stood out boldly as a landmark in the Honolulu of 1860" (p.125). It stood, in fact, among other edifices of importance: in close proximity to Kawaiahao Church, the royal palace, and Washington Place. The facility was definitely a centerpiece and a symbol of collective social elan.

What one finds in the early operation of Queen's Hospital is that it quickly became the presumed panacea for a variety of social ills. The activities of the hospital surpassed that of caring for the indigent sick to deal with venereal diseases of prostitutes, the dispensing of drugs, the treatment of chronic ailments, as well as for acute inpatient care. Outpatient care revealed an astoundingly high rate of use (Greer, 1969); while inpatient care was low to moderate. The average stay in the facility for

\textsuperscript{10} Note that the notions of civilization, Christianity, philanthropy, the Queen, and Dr. Rooke are clustered together in this piece. This clustering of persons and values place Western over Native Hawaiian characteristics in terms of piety and "progress".
inpatients between 1859 and 1903 varied between one to two-and-a-half months (Schmitt, 1977: 68).

With regard to financing, the government found various ways of keeping the facility afloat. There were direct governmental appropriations to the hospital by the legislature, of course: the biennium appropriation for 1858 and 1859 budgeted for a $2000 debit under miscellaneous expenditures. But there were also funds attached to specific legislative acts which were funneled into the hospital. The "Act to Aid in the Establishment of Hospitals for the Benefit of Sick and Disabled Hawaiian Seamen" sought to place a two dollar tax on any foreign passenger arriving from a foreign port (Polynesian, 1859: 2). Greer (1969) notes that a 1862 resolution authorized the hospital to receive $4000 to meet the costs of "An Act to Mitigate Evils and Diseases Arising from Prostitution" (p.127). As late as 1892, Queen Liliuokalani signed "An Act to Provide for the Disposition of Hospital Tax Funds" to be paid into the public treasury and held by the Minister of Finance as a special deposit to the trustees of Queen's Hospital. This had been done for decades as an informal "understanding".

The hospital, then, was very much an appendage to the kingdom government: hardly acting as a private corporation except in official legal status. It was, for all practical purposes, the public hospital that had been envisioned but remained unrealized in 1855.
Western versus Native Health Practitioners

While the Queen's hospital was still in the process of institutionalization, the medical profession itself was attempting to exert exclusive dominance in the sphere of health/medical practice. The Hawaii Medical Society had been chartered in 1856, and physicians, as practitioners, were coming into their own. Individuals such as Dr. William Hillebrand, Dr. Guillou, Dr. McKibbin, Dr. Seth Porter Ford, and so on were in the lead to politically legitimize only western medical practice. A propaganda battle over whether western physicians should have exclusive rights to practice health/medical care began raging in the press.

Only those who are so circumstanced as to be brought into frequent communication with the native aboriginal Hawaiians, and become familiar with the characters, are fully aware how deeply seated with them is their distrust of and repugnance to foreign medical practitioners, and their utter want of faith in foreign drugs. When they do submit to persuasion and take the medicine prescribed, it is often the case that they will at the same time be taking sily the mischievous decoctions of awa or some other drug at the hands of the wretched native quacks that swarm the land. The only way in which the Hawaiian sick can be doctored with any reasonable prospect of a cure is by taking them to Queen's Hospital, where they can be watched, and isolated from their friends. (Pacific Commercial Advertiser, 1871:2).

At the same period of time, the Native Hawaiian press, such as the tabloid Kuakoa, were defending the traditional practitioners against the lobbying efforts by the "foreign" press to outlaw all but western medical practice. It was
clearly the English language newspapers that were on the offensive: referring to the kahuna, who were licensed at the time, as deceivers and profit-seeking frauds whose practices were to blame for the extermination of patients and for the kingdom depopulation! (Pacific Commercial Advertiser, 1871: 2).

Under the act of 1859, Queen's was to be a training ground for Native Hawaiians in learning Western medicine. In 1872, in coincidence with the attack on Native Hawaiian health practices, ten "Hawaiian" graduates were licenced to practice western medicine. However, after Dr. Judd, the primary sponsor and advocate of the training program, suffered a stroke, the training of Native Hawaiian physicians was discontinued indefinitely.

The Queen Emma Trust, 1860 - 1899

In 1885, Queen Emma Kaleleonalani died. She had no children to survive her. Her only offspring, born the year prior to the institution she worked to create, had died at the tender age of four in 1862. Her spouse, Alexander Liholiho (Kamehameha IV), succumbed soon after the demise of their son. Emma had outlived her family and the Kamehameha dynasty, dying amidst the reign of David Kalakaua.

While alive, the dowager Queen had inherited property from her parents: George Naea and Fanny Young. Fanny Young, being of the privileged Kamehameha line, was among those
receiving large sections of land under the Great Mahele of 1848. She held claim to some 10,000 acres dispersed throughout Maui, Hawaii, and Lanai.\footnote{This was in the form of L.C.A. (Land Commission Award) 8519-B in the Mahele Books.} Her adoptive father, Dr. Thomas Rooke, also had secured claim to small plots of real estate in downtown Honolulu.\footnote{L.C.A.s 924, 3, 184. Although these were relatively small plots of land, their location in downtown Honolulu would later make them quite lucrative for the Trust.} Properties of her late husband, Alexander Liholiho, were included in the estate.

The privatization of real property had made it possible to commodify space and for individual citizens to designate the disposition of their private property beyond their death. A trust, in other words, could be created designating the specific intents of the trustor, the target of its intent, and the succession of its management.

In the separation of legal title and equitable title (i.e., the "ownership" which would have been protected by the respective courts of law and of equity) which provides the poles between which the "fiduciary duty," the electricity of the trust relationship, flows. A trust is a relationship which requires the existence of some property interest, the "res." (Mennell, 1979: 181-182).

The dowager Queen died on April 25, 1885, having left behind her a last will and testament which was dated October 21, 1884. Upon her death, the document was processed in probate court. In its text, the will identified an array of

\footnote{This was in the form of L.C.A. (Land Commission Award) 8519-B in the Mahele Books.}
beneficiaries to be provided for including two institutions in which she had played a role in establishing in the islands: The St. Andrew's Priory and the Queen's Hospital.

With regard to the former, both Emma and her husband had been instrumental in establishing the Episcopalian church in Hawaii. They had been married in accordance with the church's rites and had personally directed the lobbying of the church hierarchy in Great Britain to establish a chapel in the islands. After some negotiation, the cornerstone for the church building was finally laid in 1867, and building materials for its construction sent from England. A school for girls was built on the grounds adjacent to the church. The name of both the cathedral and school was St. Andrews: chosen for the saint whose feast day coincided with the date of Alexander Liholiho's death (Pukui et al., 1974: 210). Both the cathedral and the priory were, in a sense, progeny of the royal couple.

To the Priory, Emma directed her trust to provide for four yearly scholarships of $150 a piece. In 1884, this amount of funding was the equivalent to a full scholarship for four young girls. Later the specificity of the dollar amount would be one point of contention between the Queen's hospital, St. Andrews Priory, and the Queen Emma Trust. But at the time, it was a sizable bequest.

The Queen's Hospital Corporation was also a beneficiary of the Queen Emma Trust. The hospital was to receive funds
immediately upon the activation of the trust; but it would be sole beneficiary only when several individual beneficiaries had succumbed to death.

Upon the death of said annuitants then the trustee or his successor may sell any one or more of the aforesaid pieces of real estate free and discharge of any trust, provided the real estate remaining will, in the opinion of the supreme court, produce a yearly income sufficient to provide for the aforesaid scholarships, the proceeds derived from the sale of any land as aforesaid to be divided one-half to the Queen's Hospital. ... But if the said Albert K. Kunuiakea should die without leaving lawful issue living at his decease, then I give, devise and bequeath all the said half of said rest, residue and remainder of my said property and estate, and all the said property hereinbefore devised and bequeathed to the issue of Albert K. Kunuiakea living at his decease, to the Queen's Hospital aforesaid. (Territory of Hawaii, 1904: 53-54).

Ultimately then, the Queen's Hospital Corporation would receive the bulk of the estate. The dowager queen's cousin, Albert Kunuiakea, in fact died without leaving lawful issue. The hospital, in essence, had only to wait. For the time being, the government was providing sufficient funds for the corporation's and hospital's operation.

Political Intrigue, 1860 - 1899

Within these three plus decades, five sovereigns would sit upon the kingdom throne. Alexander Liholiho would die in 1862 and be succeeded by his brother Lot Kamehameha (Kamehameha V).
Lot would promulgate his own constitution in 1864 and adopt an interest in ancient Native Hawaiian cultural practices. Included in his activities were the revival of the hula, an interest in native health practices, and a strengthening of the throne. All these activities were looked upon by the still highly American missionary press as a reversion to heathenism. Lot's actions were the target of annexationist propaganda from the popular, English language tabloids. But, in his tenure, he had stablized the kingdom's expansive fiscal tendencies. The last in the direct line of Kamehameha I to rule, he died without naming a successor to the throne. Lot was the last in the Kamehameha dynasty.

The constitution provided for the legislature to elect the successor in the event that one had not been named by the preceding sovereign. William C. Lunalilo was elected almost unanimously by such a vote (see Schmitt, 1977: 602).\footnote{A vote was taken among the populous in which Lunalilo handily defeated his opposition. This was also reflected in the vote taken within the legislature. The system was akin to the electoral college in the U.S.} Lunalilo was the son of Charles Kanaina and Kekauluohi. His reign would only last a little over a year. At his death, he would create the Lunalilo Estate to oversee a facility for destitute Hawaiians giving preference to the elderly (Kamakahi, 1989b).
Again, elections were held to select the person who would sit upon the throne. The time the election was highly contested. Ultimately, David Kalakaua would be the victor. The reign of Kalakaua was characterized by grandiosity, fiscal irresponsibility, and a weakening of the sovereign's role. As the Hawaii - U.S. trade dependence increased, the internal forces of annexation were again activated. One result was the Bayonette Constitution of 1887, which shifted greater political power away from the Crown.

Upon Kalakaua's death, his sister, Liliuokalani, became sovereign. In her two year reign, her efforts to reinvest power in the throne only served to strengthen the resolve of the annexationists. In 1893, the so-called "Committee of Public Safety" in complicity with United States marines, overthrew her kingdom in a bloodless coup.14

A Provisional Government was formed in hopes by the usurpers of immediate annexation by the U.S. When such action was not forthcoming, the Republic of Hawaii was created.

During the continual trials and tribulations on the political front, the economic basis and underlying infrastructure remained virtually untouched. The sugar

14 The complicity of U.S. troops in this event is documented in the Blount report (Blount, 1893). Congressman Blount, of Georgia, analyzed the circumstances of the overthrow in his report to President Cleveland.
industry was king: providing the source of national income to motor the rest of the political-economic machinery.

The relationship between Queen's Hospital and the government remained pristine. The government still provided funds for operation of the facility, and Sanford Dole, President of both the provisional government and the Republic of Hawaii, served as president of Queen's Hospital as well in accordance with substantive compliance to the original charter of incorporation.

Reorganization: Queen's Hospital, 1900 - 1945

In 1898, the annexationists finally prevailed: the United States formally annexed the archipelago. The former kingdom would now be known as the U.S. Territory of Hawaii. The Organic Acts of 1900 would overlay the laws of the U.S. Constitution on existing statutes and the former would prevail in the event of conflict.

Queen's hospital would not come out of this period unscathed. The corporation would have to assess certain aspects of its hitherto accepted identity that it had maintained during the latter half of the 19th century.

Themes of the U.S. Annexation of Hawaii

The Organic Act of 1900 not only superceded previous laws and statutes that had existed in Hawaii before it, but it would force the reevaluation of certain implicit
understandings which were not previously questioned even after the Kingdom's overthrow. The emergence of three themes would have direct relevance to the Queen's Hospital Corporation and its hospital. These three themes are universality, the separation of the private and public sectors, and the place of health care with regard to the basic rights of citizenship.

The theme of universality refers to the notion that all members of a population should have access to the same opportunities given certain contingencies and without regard for irrelevant characteristics. Conversely, universality can be stated in another way, no special privilege should be accorded a subset of the population by virtue of an irrelevant (i.e., arbitrary) set of traits or characteristics. Under the new law of the land, citizenship was a relevant contingency, but ethnicity was an irrelevant (i.e., arbitrary) characteristic upon which the population at large could be divided.

A second theme that would come to the fore in the Territory, would be that of the separation of private and public sectors. Undoubtedly, this didn't mean that there could be no collusion between the sectors, but that certain private institutions could not gain special consideration by covert relations with the government. Appropriations could be made, statutes could be enacted, but all such activity would have to occur by an open, due process.
The third theme of territorialhood was that of the explicit salience of the wealth structure in social processes. With the invocation of universality and the separation of private and public sectors, the importance of wealth became increasingly more primary. One could either afford to purchase commodities, or one could not. This was important in the context in which health services became a commodity.

These three themes were no doubt in play during the kingdom, but their explication was now formal and their relevance at issue. Differences with regard to ethnicity could now be hidden under the notions of citizenship and socio-economic status. Instead of blatant racism, one could discuss "invisible" institutional or structural racism. The discourse of the kingdom was re-interpreted to fit that of capitalism and class status.

Plantations and Politics

Sugar was the territory's lifeblood, and the plantation the basis of the body politic. By 1900, there were fifty-two plantations using approximately 125,000 acres of land. At the same time there were some 35,000 plantation laborers. The plantation labor force was at its peak viz-a-viz other wage employers in general. Though the number of plantations would decline in ensuing years, the acreage allotted to sugar
would increase and the number of plantation laborers would continue to increase until the 1930s (see Schmitt, 1977).

The "Big Five" would dominate Hawaii's political-economy. These corporate plantationers would control virtually the entire sugar industry. In 1920, the following corporations produced roughly 94% of the entire sugar tonage in Hawaii: American Factors (AMFAC), 29%; C. Brewer, 26%; Alexander and Baldwin, 23%; Castle and Cooke, 10%; and Theo. H. Davies, 6% (Takaki, 1983: 20). Their domination of sugar was but a part of the picture. They had financial interests, often controlling interests, in a vast array of financial enterprises. To put it mildly, the Big Five had a strangle hold on the political-economy of Hawaii and its people.

Politics for the majority of the period was Republican and staunchly conservative. Immigrant Asians, who were denied citizenship en masse, had no voice in Hawaiian politics. Native Hawaiians and Hawaiian citizens were fragmented enough in a divide-and-rule scenario to be ineffective.\(^{15}\) After an initial spurt of kingdom sentiment, the population basically voted in accord with the Big Five interests. The governors appointed by the Presidents of the United States were largely in the same mold as the "Big Five".

\(^{15}\) See the work of Georg Simmel (1950) in discussing various aspects of "formal" sociology, especially triadic relations.
Two legislative acts of import that were contrary to the general trend of conservatism were the Workman's Compensation Act and Employee Retirement legislation. Both acts were to recognize the limitations of wages and the worker encompassed within such an early capitalist system. Labor unions were on the way from the mainland U.S. to organize worker dissent on the plantations (Zalburg, 1979). Dissent was already being expressed along ethnic lines in various actions taking place around the islands (Beechert, 1985).

In any case, although sugar was king and the Big Five its crown princes, change was slowly making way. Plantation laboring Asians who had been denied citizenship would have children, born on U.S. soil, who would be citizens in accordance with the template of universality. But, class status would keep them from the upper echelons of Hawaiian society: for a time, anyway.

The Health Sectors

Between 1900 and 1945, hospitals can be easily separated into distinct sectors: the plantation hospitals, the private hospitals, and the public facilities. Although hospitals represented a heterogenous array of facilities and services, this separation by type of ownership was commonly accepted (see Nebelung and Schmitt, 1948; Weinerman, 1952; Bolles, 1947).
The plantation hospitals were those under the auspices of the private corporations which were owned and operated on the plantations themselves. According to Nebelung and Schmitt's (1948) data, approximately twenty-six such facilities were established in toto. Weinerman (1952) studied the plantation health facilities and services for the ILWU, concluding that:

The hospital picture in the Territory is an exceedingly complex one. There is an adequate number of general hospital beds, although they are poorly distributed and are found often in too obsolete and deteriorated facilities. (pp.28-29)

And, the dual role of the physician in the plantation facilities, as had been the case in the kingdom period, was still existent. Weinerman (1952) notes that "the dual existence of the doctor-patient and the doctor-employer relationship confuses and renders suspicious those who seek medical care under the plan" (p.3). The HSPA (Hawaii Sugar Planters Association) did, however, have one of the most extensive health care plans for its employees at the time. Also, the afflictions of plantation laborers was well documented. The plantation hospitals were nested within the corporate enterprise of sugar production and served a very specific population: the plantation employees. As ancillary institutions, they were expected only to provide necessary primary care.
The private hospitals of this period were a heterogenous assortment of facilities running the gamut between small appendages to a physician's office to tertiary care facilities. Many of the former were established on neighbor islands: about eight on Hawaii, one on Maui, and one on Kauai. In general, these primary care facilities would not last out the period and most assuredly would meet their demise in the Hill-Burton Act. Some important secondary and tertiary care facilities would be developed though. Included in this category on Oahu would be Japanese Hospital (later, Kuakini) in 1900, Kauikeolani Children's Hospital in 1909, Shriner's Hospital in 1923, and St. Francis Hospital in 1927. On the neighbor islands, facilities such as Wilcox Hospital on Kauai would be created. Queen's Hospital, however, would still dominate the Territory as the major medical facility and lead with regard to tertiary care in the islands.

The public sector was continuing to expand. Unlike the kingdom period when the government was creating specialized facilities to deal with specific areas of health, the emphasis during this period was to establish satellite facilities in rural areas. Such facilities were run by the newly created county system, and in some cases appropriated plantation facilities for such purposes. The federal government also established some facilities in the islands: most notably, Tripler Army Hospital in 1907.
In general, the time of epidemic diseases ravaging the population had passed. Between 1900 and 1945, the focus was upon expanding the health infrastructure throughout the Territory. The introduction of third party insurers such as HMSA (Hawaii Medical Service Association) acted as one means by which private citizens could afford health services.\(^{16}\) Likewise, workman's compensation acts and the like served to fuse the workplace with medical services.

**Queen's Hospital, 1900 - 1945**

Queen's hospital was to notice the political shift of annexation more extensively and more immediately than any other health facility in Hawaii. The reason for this was that it's operation for the past four decades contradicted the three themes that were to be instanciated by annexation: universality, separation of private and public sectors, and the primacy of the wealth structure. No longer would the hospital be able to function as it had in the past.

In 1900, George W. Smith, then trustee of the Queen's Hospital Corporation, noted the changes of annexation in terms of the hospital.

You see there is a provision in the United States Constitution that public property shall not be taken for private use, or that the people shall

\(^{16}\) HMSA (the Hawaii Medical Service Association) is a member of the Blue Cross - Blue Shield plans which were created by hospitals and practitioners in order to receive reimbursement for services.
not be taxed to support private institutions. The Queen's Hospital is, from the nature of its character, a quasi-public institution. When it was chartered it was provided that all Hawaiians, of native birth, should be treated free of charge. Foreigners were to be treated by payment of fees.

Under the Monarchy and the Republic $10,000 was annually appropriated for its support, but now the Islands are a part of the United States this sum may be eliminated from the appropriation list. We have already lost the $1 tax which was exacted from everyone who landed on the Islands, which amounted to something over $30,000 annually, and likewise the seaman's tax, which netted us another $2,000 or more, so with this additional money lost we shall be out a considerable portion of our revenue. We have still a goodly revenue, however, from lands given to the hospital by the Queen and from other donations.

... Our income will not be what it has been in the past, but as the years go we shall have undoubtedly public hospitals, a city or county hospital, that will take part of the work from the present one, so that our funds and income will carry the work of the institution on all right. (Honolulu Advertiser, 1900a: p.2).

In the previous statement it can be seen that the executive body of Queen's Hospital recognizes that their privileged incestuous relationship with the government had come to an end. The seaman's tax and the hospital tax fund represented aspects of that past privilege. There is also the recognition that the laws of the territory call for a greater separation of the public and private sectors: and that Queen's Hospital is caught somewhere between these two statuses. The inclination of Smith is that the Queen's Hospital's role will be that of a private hospital and that eventually public hospitals will take over Queen's previous duties.
Queen's Hospital was appropriated $40,000 for the biennium. This was double what had been appropriated to the facility in the past; and double what Governor Sanford Dole had recommended. Attached to the bill was a rider that these monies would be used only for services which made no distinction with regard to "race". It was designated that the Board of Health would oversee and monitor the use of these monies. Still, however, there was concern expressed: "Under our charter we are compelled to treat native Hawaiians free of charge and I do not see how it can be changed." (Honolulu Advertiser, 1901a: 14).

On the following day, August 1st, the matter was settled to the satisfaction of all parties involved. The Attorney General reported that the appropriation was perfectly legal. Gov. Dole, a former kingdom Supreme Court Justice and previously President of the Republic of Hawaii, announced that he had examined the Queen's Hospital Corporation charter and "could not see wherein the Legislature did not have the right to create a public hospital. The appropriation was made on the condition that all races be treated alike at the hospital, and this should be done" (Honolulu Advertiser, 1901b).

Several resolutions of dilemmas facing Queen's Hospital were provisionally being negotiated. It was clear that as a private corporation, Queen's could receive public monies as long as they were used for non-discriminatory public
services. Second, it was clear that the understanding of the government and the corporation itself was that Queen's Hospital was designed to serve the Native Hawaiian "race". And third, Queen's Hospital Corporation recognized the potential conflicts now facing them as a quasi-public institution.

The increase in the biennial appropriations by the legislature made up for the losses that Queen's would suffer from the abrogation of special taxes it had previously been the sole beneficiary of. So, in terms of finances, the corporation was still on solid ground. But there was clearly an incentive to bifurcate services internally: that is, to separate services given to the public at large from those given to "Hawaiians".

In an opinion by Supreme Court Justice J.J. Perry in 1904, the major dilemmas are set out explicitly. In the opinion Perry states that public monies may be appropriated to Queen's for public purposes and still not interfere with the primary eleemosynary purpose of the institution. That primary purpose is revealed in the phrase in which he defines "Hawaiians" as referring specifically to "aborigines" of Hawaii rather than as citizens of the same (Territory of Hawaii: 1904).

In 1909, the Queen's Hospital Corporation was to make amendments to its charter. Victor Houston (1950), a part-Hawaiian who would be involved with various of the CBHEs,
would say of these changes that: "In 1909 began the maneuvering and the chicanery, which, in secret sessions and by processes that appear to have been violative of their own by-laws, resulted in upsetting the established practices of fifty years, that had been well known to Queen Emma" (editorial page). The changes that were made included the dissolution of the head of the government to sit as president of the corporation, the reduction in trustees from twenty to seven and to only represent stockholders, and for the hospital to maintain wards and apartments for the treatment of pay-patients as well as free wards for the treatment of indigent persons (Queen's Hospital Corporation, 1909).

In essence, the corporation was ascending in some ways to the parameters of the political situation. It shed the conspicuous privileged ties to the government apparatus. Further, the corporation began to assume the posture of a market orientation: that is, it would focus its attention toward paying patients as was technically allowed in their original charter. And lastly, it would speak the language of universality by no longer referring to "Hawaiians", but rather to pay-patients and indigents. In all cases the corporation was technically in accordance with themes suggested in the original charter of 1859. But for critics such as Houston (1950), being technically in line with the historicity of "precise" legal language was not the same as
adhering to the understandings of the creators of the institution (see Kamakahi, 1989c).

In a mere decade since annexation, the hospital had been transformed from a center of socialized medicine into the largest hospital in the private sector. In the years to come, Queen's Hospital Corporation would increasingly focus upon fee universality and the market orientation.

By 1939, Houston was presenting lectures at various Hawaiian Civic Clubs castigating Queen's Hospital for ignoring Native Hawaiians' medical needs and reneging on the promises of the original charter (1939). In newspapers the main themes of Houston's one man assault on Queen's was set out for the public by these questions: what ever happened to free medical care for Hawaiians and what is Queen's doing with the Queen Emma Trust monies?

The Queen Emma Trust, 1900 - 1945

It was early in the 20th century, Queen's Hospital had been already been receiving funds from the Queen Emma Trust on a regular basis. For the remainder of the period the corporation would be focusing upon the dissolution of the trust altogether. For as long as the trust corpus remained separate from the corporation per se, Queen's would be a beneficiary to (i.e., dependent upon) another agency for monies given incrementally. If, however, the corporation
could capture the entire res, then the corporation itself would be on firm financial footing.

In the period between 1900 and 1945, the Queen's Hospital Corporation would be involved in continual litigation with the Queen Emma Trust. In fact, such litigation would make its way into the Territorial Supreme Court three times.

In May of 1900, there was a question as to whether Queen Emma (and therefore her Trust) was sole heir to the estate of Emma's adoptive father, Dr. T.C.B. Rooke. Because of the language of his will, there was an estate tail (residue) which by law would have to be dispersed among heirs. It was the opinion of the court that such residue was not the sole possession of Queen Emma but had to be divided between Queen Emma and other heirs. Still, though, the bulk of Dr. Rooke's estate passed on to his adopted daughter by specific bequest. In the case, Rooke v. Queen's Hospital (Territory of Hawaii, 1900), Queen's Hospital entered such litigation as a beneficiary of the estate.

Eight years later, the Territorial Supreme Court ruled on Queen's Hospital's initial attempt to terminate the trust. The court held that it would not terminate trust property not required for the annuities remaining to be paid. Such a direct transfer of trust property was contrary to the instructions of the trust and hence unnecessary. In a concurring opinion, Justice J. Wilder wrote: "I concur
only in the conclusion of the court, but with considerable hesitation, however, for the reason that, while technically it may be correct, practically the result is to tie up property worth over $112,000 in order to produce an annual income of $1800, which seems to be contrary to common sense" (Territory of Hawaii, 1908: 64-65).

Justice Wilder's comments would represent the gist of the reasoning behind Queen's Hospital's litigation attempts. Within a capitalist wealth structure, the ownership of property reaps many more benefits than the status as beneficiary per se.

In 1939, twenty years later, the Hospital was again prepared for another round of court battles to terminate the Queen Emma Trust. In July of that year, Territorial Attorney General Joseph V. Hodgson voiced his objection to the Queen's Hospital action pointing back to changes which had transpired and altered the project of the Hospital itself dating back to the 1909 charter changes (Honolulu Star-Bulletin, 1939). The reported value of the Queen Emma Trust estate by the end of 1938 was $613,199.70: a very sizable amount (Honolulu Advertiser, 1939).

A newspaper article written in 1940 displayed a general change in sentiment in favor of the Queen's Hospital position when it stated that: "in the will there is no mention of race, nor any other direction for the use of the
money. It was left to the hospital with absolutely no restrictions" (Honolulu Star-Bulletin, 1940).

The juxtaposition of these interpretations of relationship between the hospital and the trust lies in the historical versus the technical scrutiny of the document creating the trust. In general those favoring the continuance of the trust argued that the trust instrument was created within the context of a particular understanding of the hospital's mission: i.e., to provide free care for sick and indigent Native Hawaiians. They pointed to the legislative context under which the hospital was chartered and it's mode of operation at the time of the Queen's death. Those arguing in favor of the trust dissolution, focused upon the particular wording of the trust instrument designating Queen's Hospital as sole beneficiary with "no strings attached".

The battle of interpretation would continue to rage for several more years. Toward the end of 1944, the positions would be restated in the public media.

Although the Queen’s will provided for the establishment in Honolulu or its vicinity of a hospital for the relief of sick and destitute Hawaiians, the trustees of the institution bearing her name have too long ignored her wishes in that regard. ... Taxpayers have a stake in the matter too, claimed the spokesman of an opposition group. The 1941 legislature took off the shoulder of Queen's hospital and every other like institution all financial responsibility for the indigent sick of Hawaii. [An opposition group composed of C. Honeywell, George II Brown, Dr. James Morgan, and J. Wilson, etc.] (Honolulu Advertiser, 1944a).
There is no requirement in the will or in the charter which requires the hospital to give free treatment to anyone. During Queen Emma's lifetime the government paid for the free treatment of indigents, and since 1909 the City and County of Honolulu has paid therefor. At the present time the public welfare fund is available for the purpose. ... Queen Emma made an absolute gift of her residuary estate to The Queen's Hospital (subject only to the payment to the Priory) for the general purposes of the hospital, and the supreme court has determined that. ... The Queen's Hospital, like all charitable corporations, is subject to the visatory powers of the attorney general. [C.R. Hemenway, Queen's Hospital President]. (Honolulu Advertiser, 1944b).

The Queen Emma Trust rounded out the period between 1900 and 1945 in the throes of litigation. But, the res remained intact and growing in monetary value. The court and media battles would continue on to the next period of Queen's Hospital's trajectory.

Reorganization: Technological Medicine, 1945 - 1980

There is little doubt that federal legislation was having an impact in the realm of health services and practice. The Sheppard-Towner Act of 1921 had assisted Kapiolani Hospital's upgrading, the Veterans Act of 1924 assisted Tripler Army Hospital, and Title V of the Social Security Act of 1935 allowed for greater access to medical care to the civilian population in general. But in terms of acute medical care, no act of federal legislation was to have the impact of the Hill-Burton Act of 1946. In Hawaii, the Hill-Burton Act would redefine the health sector and
define a hospital as a facility which provided tertiary care.

Hawaii, 1945 - 1980

World War II was expanded into the Pacific arena and had focused attention upon the Territory's strategic location in the political scheme of things. The influx of war related personnel and monies into the islands' economy served to integrate Hawaii with the body politic of the United States.

Nineteen-forty-five seems to be a point of discontinuity in Hawaii, where a number of changes were occurring simultaneously. The sugar industry was reaching the saturation point in terms of acreage and the plantation labor force was decreasing rapidly. Children of non-citizen plantation laborers were now fully fledged citizens and began exercising their privileges as such. The proportion of the population engaging in elections, which had hovered around twelve percent, was to begin climbing. Also beginning startling upward trends were the amount of public debt, taxes per capita, number of corporations, and real property values (see Schmitt, 1977).

Public reinvestment into the public and private sectors was the focus of attention. The push was on for Hawaii to shed its territorial status for statehood. Labor was now organized and the Democratic party in Hawaii was making an
impact in island politics. The crux of power was being balanced by an insurgent group of politicians that were ready to take the dominant Republican party and the ubiquitous Big Five to task.

The Republicans ushered out the Territory and the Democrats brought in Hawaii's change into Statehood. By 1962, the Democratic party in Hawaii, for the first time, controlled both houses of the state legislature with a Democratic governor at the head of the executive branch. It would be the beginning of the reign of the Democratic party in Hawaii: a party that endorsed centralized planning and decision-making as well as public reinvestment (see Daws and Cooper, 1990).

The focus of the entire period between 1945 and 1980 would be that of building and consolidating infrastructure. During that time sugar would be dethroned by government (inclusive of military) and tourism as revenue producers.

The Impact of the Hill-Burton Act of 1946

The single most influential piece of federal health legislation during the period, and perhaps during any period in U.S. history, was the Hospital Survey and Construction Act of 1946: also known as the Hill-Burton Act. The act had two major objectives: (1) to inventory and evaluate existing hospital facilities and (2) to construct public and other
non-profit hospitals in accordance with the act (see Lave and Lave, 1974).

The act was set up as a federal-state partnership. Each area was to be given an initial grant by which to survey their facilities and to develop a plan accounting for health facilities and health "needs" with regard to certain specific criteria.

In Hawaii, the territorial government scrambled for inclusion. In the ensuing years a number of studies would be created within the auspices of such a purpose: Bolles (1947) by the Hospital Service Study Commission, Board of Health (1948), Nebelung and Schmitt (1948) by the Honolulu Chamber of Commerce, and even Weinerman (1952) by the ILWU.

Bolles (1947) counted a total of sixty-two hospitals to be in existence at the time. Of this census, forty were general hospitals, eight for chronic care, five in allied specialties, four for tuberculosis, two each for mental health and leprosy (p.12). Obviously, the term general hospitals was used quite broadly to refer to those small facilities providing only primary care as well as to those providing secondary and tertiary care.

Although the exact number of facilities differed somewhat in each particular study, it was clear that there were only a few facilities which fit the new understanding of the term "hospital".
By 1952, many facilities mentioned by Bolles (1947) no longer qualified as general hospitals. Weinerman counts a total of twenty-three: nine on Oahu, six on Hawaii, four on Maui, two on Kauai, and one each on Molokai and Lanai (p.33). He notes that:

In Honolulu, an adequate set of hospitals serves as the base for the entire Territory. ... In the rural areas and smaller towns the problem has been that of an array of small, under-occupied, poorly staffed and equipped, inefficient and close-together hospitals ... rather than a problem of under-supply of beds, as is true of mainland rural areas. (Weinerman, 1952: 29).

Many of the smaller plantation and privately owned-and-operated facilities were downgraded or eliminated altogether by Hill-Burton. Certain strategically located facilities were targeted for improvement and public monies while others were made defunct. The Act basically served to standardize hospital care as well as terminology throughout the Territory and in line with the country at large.

The availability of federal monies for such programs also meant that some Territorial monies were freed up for appropriations to the private sector as well. The designated hospitals that survived the initial Hill-Burton scrutiny were to play an even more central role in the scheme of Hawaii's health sector.

But it wasn't until 1957, when the territorial legislature would actually get to the chore of hospital and
medical facility construction (Territory of Hawaii, 1957a: 49).

The Queen Emma Trust, 1945 - 1967

The battles that were raging between Queen's Hospital and the Queen Emma Trust were at a climax. In 1950, again the conflict surfaced in the Territorial Supreme Court. On May 3, 1950 the case of Queen's Hospital v. Hite, Trustee, et al. was decided (Territory of Hawaii, 1950).

The arguments on behalf of both parties had not changed very much since the 1908 Territorial Supreme Court case of Queen's Hospital v. Cartwright (Territory of Hawaii, 1908). Queen's Hospital wanted complete control of the Trust's corpus and argued that the Trust should be dissolved after having outlived its practical usefulness. The Trust argued that the intent of Queen Emma was to have the hospital as a beneficiary of the trust res as long as such property provided a sufficient annuity. The opinion of the court was, for the first time, in favor of Queen's Hospital.

The time for strict compliance with the will has long since passed. The Queen's Hospital as sole beneficiary of such compliance, however, does not insist upon it, but does insist upon substantial compliance to have the excess real estate in lieu of proceeds of sale thereof distributed to it forthwith. To do so at the election of The Queen's Hospital would not defeat any material purpose of the will. The situation as it is today thus obviates strict, but calls for substantial, compliance with the will. (Territory of Hawaii, 1950: 520).
The decision by the Supreme Court of the Territory reversed forty-two years of legal decisions on the matter including circuit court decisions by Circuit Judge C.H. Buck in 1947 and Circuit Judge W.C. Moore in 1948.

As a result of the decision, Queen's Hospital received assets valued in 1950 at $2,750,000 from the trust corpus. The only property not turned over to the hospital was a 10,000 square foot parcel that would continue to pay the $600 in scholarships to the St. Andrews Priory and was still held by the Queen Emma Trust (Honolulu Star-Bulletin, 1950).

In 1967, the residual of the Queen Emma Trust passed on to the Priory with certain restrictions by circuit court Judge A.R. Hawkins (Honolulu Advertiser, 1967). In short, the Queen Emma Trust had officially been terminated as a legal entity. Because of the restrictions on annuities by the court, St. Andrew's Priory agreed to sell the real estate to Queen's Hospital. Queen's Hospital was to purchase real estate worth upwards of one million dollars at the time for a mere pittance: $25,000 (see Kamakahi, 1989b).

With the transfer of property from the trust to the hospital, Queen's Hospital had received parcels around the territory including 16 acres in Waikiki and lucrative parcels in downtown Honolulu. The bulk of such properties

\[17\] The Priory could only, under the court's interpretation, usurp $600 annually from the real property's value. The amount had been specified in the original will.
would be managed by the hospital under a newly created entity: the Queen Emma Foundation (see Kamakahi, 1989b).

The Queen's Hospital, 1945 - 1967

The Queen's Hospital's receipt of property from the Queen Emma Trust in 1950 represented a boon for their coffers. The hospital was seen as embarking upon a "new era" in its history. With its new real property assets, which included parcels in Waikiki and 1500 acres in Halawa, the hospital corporation could boast of assets worth upwards of $4.5 million. The institution was also privy to legislative appropriations and a 75 cent daily subsidy for each indigent ward bed that qualified. And about 80% of all physicians licenced to practice in the territory received their intern training at Queen's (Honolulu Advertiser, 1950).

Appropriations from the legislature were by no means consistent from session to session. In 1957, Queen's was the recipient of the largest appropriation for any private hospital: $92,710 (Territory of Hawaii, 1957b: 147). Then, in 1959, they were one of many facilities to receive a subsidy of $10,000 (Territory of Hawaii, 1959: 298).

Queen's Hospital was the largest facility in the state and held interests in a number of ventures and prospective ventures. The Board of Directors for much of the period, though, remained unchanged.
The Queen's Medical Center, 1967 - 1980

On November 27, 1967, the Department of Regulatory Agencies approved the request for the facility's change of name. From that date forward, the facility would be known as the Queen's Medical Center (State of Hawaii, 1967).

Internally, the change did little. The change in designation from hospital to medical center, however, was not entirely arbitrary. The latter designation was indicative of their ability to offer the most extensive available tertiary care services in the State of Hawaii. The corporation had set the stage for its prospective expansion: it possessed the resources, the status, and now as well as a new project. The project was total medical care.

By 1969, the medical center was formally proposing expansion to the tune of $9 million. They sent their plan to the City Planning Department to rezone the area contiguous to the hospital to allow for a ten story physicians office building, a four tier parking structure, and a new surgical wing (Honolulu Advertiser, 1969). At this time, the annual operating budget was approximately $12 million, almost entirely financed by income from patient charges. In addition, the medical center possessed a medical staff comprising of 650 physicians (with 75 interns and residents) as well as 1200 employees in 400 job classifications. About five percent of the budget was
allocated to "charity" patients. As one Queen's official put it: "When Queen's concept of total care becomes a reality, we will be a one-stop center for medical, surgical, pediatric, obstetrics and psychiatric care, and we will have facilities for drug and alcohol problems as well" (Honolulu Advertiser, 1970).

At about the same time, the medical center was in the process of phasing out "poor wards" per se, in light of the increase in the State's DSS (i.e., Department of Social Services) reimbursements. There would no longer be the spatial bifurcation of "charity" versus pay patients within the facility.

On the immediate horizon were plans to create a mental health facility on the grounds. The 1972 State legislature obliged by allocating the medical center $500,000 under Hospital Grants-in-Aid to be expended by the Hawaii State Department of Health. The grant was designated specifically for the "planning and construction of a mental health facility. [To supplement prior appropriations]." (State of Hawaii, 1972: 576).

Throughout this time it was apparent that Queen's still represented the center of medical care in the State of Hawaii. As the largest and the most capital endowed facility, new partnerships with the State were coming to fruition. In 1978, the State released $2.3 million for the planning and construction of facilities for the John A.
Burns School of Medicine as part of the University of Hawaii's medical school program (Honolulu Star-Bulletin, 1978). Also forthcoming in the years to follow were a cancer institute (in conjunction with the State), a new wing, the purchase of Molokai General Hospital, a clinic for low income persons, and a health insurance venture. In other words, the medical center was just one facet of what would now be called the Queen's Health Systems (see Kamakahi, 1989c).

The fuel for these activities was the corporate leadership itself, but the motor was the monies of the trust now in the entity of the Queen Emma Foundation.

Recasting A Vision: Queen's Health Systems, 1859 - Present

This chapter, thus far, has presented a progressive/regressive account of what is presently Queen's Health Systems. In the process, the text has focussed upon certain aspects of the corporation's development. At this juncture, a commentary will be made being attentive to crucial issues in that trajectory. It is not the position of the author that the ensemble had to develop in the manner that it did either because of it's political-economic context or the dictates of it's charter or the make-up of its policy making board. Such accounts would be reductionist.
Rather, an attempt will be made to illustrate that the trajectory of the ensemble was the product of conscious situated efforts by political agencies (including the policy making boards of Queen's) to adopt certain projects and, concomitantly, to feign and reject others.

Given the place of Queen's within the kingdom, there would have been little incentive for the "quasi-public", eleemosynary institution to be anything other than the center of socialized medicine in Hawaii. It eventually enjoyed a public legitimacy as well as a virtual monopoly of public expenditures for the purpose of primary, secondary, and tertiary health care not allocated for the control of contagious diseases.

The annexation of Hawaii by the United States disrupted the comfortable arrangement of the ensemble. This event had immediate and extensive implications for Queen's. The themes of universality, separation of private and public spheres, and the primacy of the wealth structure were introduced. One thing was clear, the ensemble could no longer operate as it did in the past.

Queen's people did have a number of choices to make. Was it going to focus upon the care of indigents or upon those able to pay for treatment? Was it going to primarily serve Native Hawaiians or would it open it's doors to the population of Hawaii at large? Would it remain in primary care, move to the periphery, or attempt to incorporate the
newest in medical services? Would the hospital continue to exist as a "quasi-public institution" or would it dissolve itself perhaps re-emerging in the public sector? The alternatives were numerous. The question was how would the policy makers of the ensemble and associated agencies choose to act? In any response to these dilemmas, the ensemble could find some justification for their actions within the confines of the charter of incorporation of 1859. The issue, then, became not that of what the charter dictated, but rather, how the decisions made would be couched within the language of the document and the ensemble's history. Would history be ignored as superfluous sentiment or would it be prominently displayed?

Queen's did make some choices; and the preceding text demonstrates that the dilemma was entirely conscious and vigorously debated. Among the choices that the ensemble made were: (1) to focus upon pay patients (i.e., adopt a market orientation), (2) to attend to Hawaii's population at large rather than to just Native Hawaiians, and (3) to remain in the core of Hawaii's medical sector. These decisions were debated in 1900, and formalized in the charter amendments of 1909. These choices, however, were not pre-determined in any sense of the term by charter, political-economy, or anything else.

Once the new template had been decided upon, certain activities would be engaged in as a matter of rationality:
as means for bringing about certain ends within a given context (see Weber, 1946). Among these activities in Territorial Hawaii would be to enter the health care market, lobby the appropriate governmental agencies, establish a sound financial foundation (i.e., a capital basis), and pursue dominance in all facets of medical care and service (e.g., primary, secondary, and tertiary).

The corporation traded in its formal ties with the government for informal and legitimized ones (i.e., government appropriations and grants-in-aid). It kept itself center-stage as medical practice changed. And, it constantly pursued the trust corpus of the Queen Emma Trust. Once the ensemble was successful in this last regard, it began an aggressive program of expansion. The expansion included a development corporation, a physician's office building, modern equipment, ensemble-State partnerships, and health insurance ventures. The expansion, then, was not just in tertiary care, but in politico-geographic influence and reached beyond the health sector itself.

Ideologically, the ensemble's "mission" was accounting for these transformation in its discourse as expected, inevitable, and foreseen (see Kamakahi, 1989c). The ensemble's mission would be recast to justify a posterni its actual trajectories. The term "Hawaiian", we are to believe, was always intended to mean the people of Hawaii regardless of ethnicity. Care of indigents seemed to be an
afterthought secondary to the providing of first-class medical care for everyone. And the vision of Queen Emma not only extended to all people in Hawaii, but to the entirety of the Pacific. The ensemble, then, would have us believe that the themes of universality and tertiary medical care were in the utmost salience of the Queen's thinking in the Hawaiian Kingdom of the 1850s.

These retrospective interpretations of the corporation's mission were, in fact, beyond the horizons of expectations and thought in the Hawaii of the 19th century. The illusions of the royal mandate, the perpetual mission of tertiary care, and the immediate legitimacy of the enterprise, are all part of the continual fiction which attempts to legitimate tremendous transformations in the guise of necessary and prescribed protocol. In fact, this propaganda is a new discourse which employs textual "slight of hand" to detract from historical fact and volitional activities (Kamakahi, 1989c).

However couched, the ensemble is startlingly different in 1990 than it was, or could have been imagined to be, in 1859 when it was established. And philanthropy, especially in the form of the Queen Emma Trust, played a significant role in this transformation.
The Role of Philanthropy

The role of the Queen Emma Trust was important in the expansion of Queen's Hospital once the corpus of it was transferred from the former to the latter. The relationship between these two entities will briefly be summarized.

First, it is important to remember that the Queen's Hospital was created temporally prior to and independent of the Queen Emma Trust. The hospital was established in 1859 and the Trust in 1884. Each, then, is structurally autonomous of the other. Their only relationship, between the 1880s and 1950, is that of the transfer of annuities between the trust and a beneficiary. The relationship is univocal; and the only intermediaries are the Queen Emma Trust trustees and the Hawaii Supreme Court.

With the annexation of Hawaii by the United States, the corporation begins litigation to acquire ownership of the trust res. The allotments to the hospital had increased because of the demise of other individual beneficiaries. But, ownership of the res would represent a substantial gain in equity for the corporation. In 1950, the bulk of the Trust was transferred to the hospital; and in 1967 the hospital would acquire title to the Trust's entirety. With these properties, the ensemble is on impeccable financial footing and in a position to further consolidate and even increase its influence in the health sector.
The important aspect of the dissolution of the trust is that the same arguments are presented on the part of conflicting parties. The context of meanings rather than the particular vocabularies of motive are of interest, because the arguments remained basically the same throughout the conflict. These changing contexts of meaning and sentiment provided the milieu within which the efficacy of the arguments were evaluated. When the trust restrictions were finally deemed too archaic and contrary to the "spirit" of the trust intent, given the exigencies of beneficiaries, the size of the trust res, and the political-economic environment in operation, the Trust became incorporated into the corporation.

At this point, the now hypothetical trust can be spoken of as nested within the Queen's Hospital Corporation. In essence, the Trust is transformed into the Queen Emma Foundation (see Kamakahi, 1989b). It is when the properties are nested within the corporation that full benefit and control of it are realized.

The relationship between philathropic equity and an ensemble is of utmost importance. For only if such philathropic influence is external and significant does it direct/control it's beneficiary's trajectory. In the case of Queen's Hospital, the Trust was originally external, but not essential for the hospital's functioning either legally or financially. The trust corpus only became significant to
the hospital's project when it was dissolved into the ensemble itself.
CHAPTER 4

THE LUNALILO HOME

An oppressive class that is on the way out is mingling the old myths with the new. At times, it justifies its privileges by the excellence of its culture and taste, that is, by its aptitude for conserving. (Sartre, 1963:202).

This chapter provides a discussion of the Lunalilo Home. Although it was founded a decade and a half after the Queen's Hospital, the Lunalilo Home was actually the first philanthropic project emanating from the royal families. The Lunalilo Trust, from which the Home was created, predated the Queen Emma Trust by a little more than a decade.

As the original royal, philanthropic project within the kingdom, the Lunalilo Trust set the tone for the disposition of real properties through the trust instrument.

In this chapter, the Lunalilo Trust and its progeny, the Lunalilo Home, are examined within the context of Hawaiian history.

Organization: The Will, 1871 - 1874

The will of William Charles Lunalilo was written in 1871 with the assistance of attorney A. Francis Judd. At that time, the properties which he had garnered from the Great Mahele of 1848 were of little monetary value. In
fact, Lunalilo himself was "land rich" but "cash poor". When the will was created, he assumed that there would be no foreseeable change in this state of affairs.

The terms of the will and codicil set out specific guidelines for the creation and the direction of the trust itself. The trust res was comprised mostly of land holdings. In order for the institutional approach to be put into action, the land, or at least some portion of it, was to be converted into cash. William Lunalilo instructed the sale of real properties to the sum of $25,000. Such monies were to be used for the erection of a building or set of buildings on the island of Oahu.

The building, once constructed, was to serve a diffuse purpose. It was to be "for the use and accommodation of poor, destitute and infirm people of Hawaiian (aboriginal) blood or extraction, giving preference to old people" (Kingdom of Hawaii, 1879a). Apparently, then, the problem of pauperism was a concern which Lunalilo felt warranted attention.¹

The trust itself was to be directed by three trustees. These trustees were to be nominated by the majority of the Kingdom Supreme Court (Kingdom of Hawaii, 1879a): the highest court in the land composed of three members. Beyond the very specific direction to sell real property to the

¹ The Queen's Hospital, previously, had been established in 1859 for destitute and infirm Hawaiians availing themselves to medical care in the Kingdom.
amount of $25,000, the immediate mission and actions of the trustees was quite ambiguous.²

William C. Lunalilo

In 1871 when Lunalilo was composing his last will and testament, he had had no experience in politics nor did it seem as though he would. At that time, Lot Kamehameha (Kamehameha V) was embarking upon the eighth year of his reign.

William Lunalilo was born in 1835 to Charles Kanaina and Miriam Auhea Kekauluohi. He was born of ali'i blood, being a grandson of a half-brother of Kamehameha I (Kuykendall, 1953). Both of his parents had had strong ties to the Kamehameha family: through marriage and friendship. Because of this, Lunalilo did quite well, in terms of acreage, in the disposition of land to citizens in the Great Mahele of 1848.

Like the others who would sit on the throne in the last half of the nineteenth century, Lunalilo would attend the Chief's Royal School. By most accounts, Lunalilo excelled at the social graces though he was quite aloof of serious political and social issues of the time. The creation of the trust, which occurred prior to his rise into the

² What specific services did "use and accommodation" include? Health and custodial care were furnished. But the actual parameters of the Home's activities were left to the trustees to decide.
political limelight, in many ways contradicts this caricature. Indeed, Lunalilo recognized what he saw as the growing pauperism in the kingdom. Not only did he identify it, but he was the first of the royal family to use the trust as an institutional instrument for addressing this social issue.

As Prince, Lunalilo had suffered from ill-health (i.e., tuberculosis) which was aggravated by his alcoholism. His affinity with pro-American sentiment probably contributed to Lot Kamehameha's refusal to name Lunalilo as a successor; though Lunalilo, by genealogy, would have been the most likely to ascend to the position.

Lot Kamehameha, in fact, did not name a successor to the throne. As a result, and in accordance with the existing constitution of the kingdom, an election was held. The contest pitted five candidates against one another: William Lunalilo, David Kalakaua, the dowager Queen Emma, Princess Ruth Keelikolani, and Bernice Pauahi Bishop. In the 1873 plebiscite, an astounding 99.6% of the 12,581 votes

---

3 David Kalakaua would succeed Lunalilo, again by election, as King; and Kalakaua's sister, Liliuokalani, would reign after him. Queen Emma had been married to Alexander Liholiho (Kamehameha IV) and had been instrumental in establishing Queen's Hospital and the Episcopal Church in the islands; she would also later create the Queen Emma Trust. Princess Ruth Keelikolani was perhaps the richest woman (and person) in the Kingdom; upon her death she bequeathed the bulk of her property to Bernice Pauahi Bishop. The latter was married to Charles Reed Bishop and together they would create the Bishop Estate and Kamehameha Schools.
cast were for the candidate Lunalilo (see Schmitt, 1977: 602). Hawaii's first elected king would take the throne on January 8, 1873.

Upon election, the first order of business for King Lunalilo was to name his cabinet. Charles Reed Bishop, a banker and husband of Bernice Pauahi Bishop, was appointed as Minister of Foreign Affairs. A. Francis Judd, the attorney who had assisted in the codification of Lunalilo's will, became Attorney General. Edwin O. Hall, a businessman and former missionary, was appointed Minister of the Interior. Robert Stirling, the only non-American of the bunch, was given the post of the Minister of Finance. It was, in all, an administration that was acceptable to the foreign community in the islands (Kuykendall, 1953: 246).

Lunalilo would suggest changes to the kingdom's constitution which would nullify those instituted by his predecessor in 1864 (Lydecker, 1918). Of particular note was his proposal suggesting the approval of a Reciprocity Treaty for sugar exports with the United States in exchange for allotting the U.S. the exclusive use of Pearl Harbor. The plan did not sit well with the populous, and the proposition was soon withdrawn (Kuykendall, 1953).

By August of 1873, Lunalilo would be taken quite ill and would never fully recover. He would die on February 3, 1874. In his brief reign, he had re-established a strong pro-American stance in government policy to match the
already interdependent trade ties which existed. But, the kingdom, again without a successor to the throne would be awash with politicking.

More significant than any of the policies which he enacted while sovereign was the activation, upon his death, of his will and codicil within which was contained the trust instrument.

By April of 1874, two months after his death, the Kingdom's Supreme Court was examining the will of the late king. The court had to rule upon the validity of the document given that at its creation William Lunalilo was under the guardianship of a spendthrift: apparently his attorney, Mr. Judd. Justice A.F. Judd, who had been the attorney that had written the will and codicil, excused himself from the case. The court found that guardianship of a spendthrift did not incapacitate a person's ability to make a will (Kingdom of Hawaii, 1874). This meant that the directions for the creation of the trust could now be executed.

The first trustees, selected by a majority of the Supreme Court as directed in the will of Lunalilo, were Sanford B. Dole, J. Mott-Smith, and Edwin O. Hall. Dole was the son of missionaries and an attorney; later he would become a Supreme Court Justice in Hawaii, the President of

---

4 A spendthrift is a person or persons designated to manage the financial and estate affairs of another.
both the Provisional Government and the Republic of Hawaii, and then the first appointed Governor of the Territory of Hawaii. Mott-Smith was a dentist by training, but gained notoriety as the first editor of the Hawaiian Gazette tabloid and in the service of the kingdom government. Hall, was a former missionary who had been editor of the Polynesian (at some times a government tabloid), a businessman, and had also served in Lunalilo's cabinet as Minister of the Interior. These were the people that were to execute the first order the business of the trust: the selling of real property for cash.

**Pauperism, Ethnicity and the Elderly**

The diffusion of social policies, both problems and solutions, were just beginning to make their way throughout society. The first constitution of the government had been promulgated only three decades earlier and the privatization of real property only two decades hence. Queen's hospital had only existed for twelve years, the Hawaii Medical Association for fifteen years, and the Hawaiian Board of Health for only slightly longer than that. Three dimensions of interest indicated within the trust instrument of Lunalilo were pauperism, ethnicity, and the elderly.

Lunalilo was not in the vanguard in recognizing destitution within Hawaiian society. Even though the
transformation of Hawaii into modernity was just beginning to occur the recognition of destitution was widespread.

The will specified that the trust was designed to serve the "poor, destitute and infirm" (Kingdom of Hawaii, 1879a). Pauperism refers to: (1) one who is extremely poor as well as (2) one who is living on public charity (Morris, 1979). The trust represented a public use of private funds. The extensiveness of poverty among the population is not exactly known, but no doubt the shift to the privatization of real property and a cash economy were integral in the dissolution of communities. Contributing to this were the waves of epidemics which blew through the Kingdom and the spreading prevalence of leprosy. Whatever the case, Lunalilo recognized destitution as a focus of concern.

Lunalilo was also explicit in targeting the Hawaiians of aboriginal blood or extraction: i.e., the Native Hawaiians. At the time of the will's creation, the population of the kingdom was about 86% "pure" Hawaiians: 90% full and part Hawaiian. The absolute population figures were discouraging: the population of the kingdom had been in a steady decline. The significance of Lunalilo

---

5 The term public refers to that which concerns or affects the community or the people; and does not necessarily refer to those activities carried out by the State.

6 The term Native Hawaiians is a "post-modern" creation used to distinguish the ethnic group descended from aboriginals as opposed to those which are "Hawaiians" by citizenship or by birth within the territory of the islands.
specifically identifying Native Hawaiians was that he may have recognized them, ironically, as a minority group: i.e., the group which was becoming distanced from the mechanisms of power during the transformation of society.\textsuperscript{7} While it was the case that the royal families occupied the executive branches, the salience of class stratification was coming to the fore and national policy was in the hands of trade and commerce in which Native Hawaiians were conspicuously absent.

Another facet of Lunalilo's legacy was contained in the phrase "giving preference to the elderly" (Kingdom of Hawaii, 1879a). Note that this was not in fact a parameter of the trust, but rather the statement of a preference. At about the time of the will's creation, roughly 72\% of the population was over 15 years of age; and 31\% of the population was over 40 years of age. This at a time when the life expectancy at birth in Honolulu would have been somewhere in the neighborhood of 25 years. The age specific life expectancy rate for those reaching their fortieth year was about 17.95 (see Schmitt, 1977: 52). In other words, although Hawaiian society had not undergone the

\textsuperscript{7} Minority group is used sociologically to mean a group not in "power" rather than referring to absolute numbers of people within a given classification.
"epidemiological transition"\textsuperscript{8}, the population demographics reflected a top-heavy, aging structure. William Lunalilo was quite perceptive in recognizing the changes transpiring within the kingdom. The prince would do more than recognize these changes, he proposed to create an institutional solution to them in the form of a philanthropic project.

Seriality: pre-1871

It is not known when Prince Lunalilo consciously organized the outlines of his trust. The codification of the idea, in 1871, was ostensibly one culmination of it. But its genesis lay in Lunalilo's conception of the social issues and their solutions.

The Mahele of 1848

The Mahele of 1848 paved the way for the "modernization" of the kingdom society. As a new system of land adjudication, the enactment of this legislation struck at the core of traditional cultural arrangements. The act

\textsuperscript{8} A society is said to have undergone an epidemiologic transition when the proportion of young to old within the population equalizes and the diseases which are of utmost concern are of a chronic rather than infectious nature. In the 19th century Kingdom, infectious diseases were of paramount concern.
basically changed the feudal-like system of land management into that of private land ownership.\(^9\)

Probably more fundamental than the legal transformation of land from 'aina to capital was its implications for the dislocation of communities. The community, its agricultural practices, its social order, and its discourse revolved around the 'aina. The land divisions, as well as their subunits, were managed in quite organized and oft times complex systems. Inhabitants of these land divisions were materially and psychically involved within such systems (Handy and Fukui, 1972).

The Mahele basically fractured the foundation of this interdependence. It replaced the system of communal organization with atomization through the creation of private ownership and privileged use. People had to make claims to certain properties: hopefully with corroborating testimony from others in the area. Such claims could only be made by "private citizens" on land upon which they actually labored and lived. There were exceptions though for those connected with the royal family and, of course, for the government per se.\(^{10}\)

---

\(^9\) There is some argument over the use of the term "feudal" to describe ancient and early Kingdom Hawaiian society. I use the term "feudal-like" generically to refer to a system of land management in which the highest status actors appointed certain underlings control over the resources and people of a given area.

\(^{10}\) Records of such testimony are in the Native and Foreign Testimony volumes housed in the Hawaii State
The impact of the Mahele was exacerbated by the coming of the cash economy. The privatization of real property meant that the value of land could now be quantified and assessed. By 1859, only a decade after the Mahele had been approved by proper government channels, taxes on such property and the majority of other taxes were payable only in cash, whereas taxes could previously be paid in kind (e.g., hogs and tapa cloth) (Schmitt, 1977: 612-613).

People were being brought into the money economy through the increasing expansion of the State. And with little knowledge of the legalities and the implications of this expansion, a set of propinquitous generations were forced to fend for themselves. Communities already affected by dwindling populations and migration to urban areas were only vestiges of their former activity.

The State had recognized the destitution created by the new social order; Queen's Hospital and the Kaluapapa leper colony were examples of this. The philanthropic project of Lunalilo would recognize some of the emergent problems in focussing upon destitution and the infirm with an emphasis upon the elderly.

Lunalilo's Land

The genealogical ties of Lunalilo to the Kamehameha line were quite strong. Lunalilo's father, Charles Kanaina, had been a close friend of Kamehameha I (Day, 1984: 70). But his claim to royalty was through his mother, Miriam Auhea Kekauluohi. Kekauluohi was one of five wives to Kamehameha I and after his death a wife of Kamehameha II (Liholiho). Her sister, Queen Kamamalu, was also married to Liholiho: dying with him on their trip to London.¹¹ In 1834, Kekauluohi married Kanaina and they bore a son: William Charles Lunalilo.

Kekauluohi died in 1845, when the young prince was ten years old. Kanaina, however, would outlive his son by three years. Kanaina, though, was privy to little claim to land being only married into the royal family. Rather, it was his son, Lunalilo, who would reap the benefits of the Mahele legislation.

Those of the Kamehameha lineage could claim an assortment of properties throughout the kingdom without the restriction of having lived upon or worked it. Also for a small fee, they could attain a royal patent on such property: such a patent being more secure than the simple land commission award (Chinen, 1958). Those whose genealogy

¹¹ The royal couple, Liholiho (Kamehameha II) and Kamamalu died in Great Britain from the measles. Succeeding Liholiho to the throne was Kauikeauoli (Kamehameha III) who would promulgate the kingdom's first constitution and bring forth the Great Mahele of 1848.
were not of the Kamehameha line, even those who in the traditional (i.e., pre-kingdom) system would have had a higher status than the Kamehamehas, had to take their place among the populous (see Kamakau, 1961).

Lunalilo would lay claim to some one hundred and fifty thousand plus acres of land. These real properties were dispersed throughout all major islands of the kingdom. They ranged from tiny house lots in Honolulu to a sixty thousand acre plot in Keaau on the island of Hawaii. These were the properties that constituted the corpus of the trust that the prince, and later king, would create in his will and codicil. The Mahele ultimately served to superimpose wealth status onto cultural status.

**Institutionalization: 1874 - 1927**

Lunalilo reigned for only a year and twenty days. Upon his death, his will and codicil were probated. The validity of the document was questioned in these proceedings and the question sent to the Kingdom Supreme Court for a ruling. Despite contention, the document was found to be valid under kingdom law (Kingdom of Hawaii, 1874).

Three trustees were selected, as specified in the will, by a majority of the Supreme Court. They were J. Mott-Smith, Sanford Dole, and E.O. Hall. Their first orders of business were to sell real properties until $25,000 had been secured and to begin making arrangements for the creation of
the facility for destitute and infirm Native Hawaiians. The trustees immediately began the disposition of lands by sale and auction.

In the meantime, a temporary facility was erected on the grounds of the Kawaiahao Church in Honolulu. This makeshift arrangement located his legacy adjacent to Lunalilo's last resting place: his Royal Mausoleum built in 1875 (Kingdom of Hawaii, 1879b).

It would seem that Lunalilo did not expect the sale of his real properties to achieve the amount of $25,000. He allowed only for the opposite contingency: that if such sales were insufficient in securing that revenue, that whatever monies raised should be invested until such an amount were obtained. Within the context of a cash poor society, it is little surprise that much of the lands were sold to those of non-aboriginal lineage: the smaller "foreign community", by virtue of their political and economic positions, represented the dominant group. This intra-majority group intimacy led to charges, nearly a century later, that the estate lands were "sold by the trustees to themselves, their friends, and business partners, and even to the Supreme Court Justices; in essence, the Estate was plundered" (Amalu, 1983). It is,

---

12 The term majority group is used not to refer to the absolute number of people in this classification scheme, but rather with regard to their political-economic dominance within kingdom society at the time.
however, quite doubtful that there were many people that could afford the lands auctioned and even less that were interested in acquiring them. Members of the royal family were already land rich and the notion of land ownership as an capital investment was not widespread among the Native Hawaiian community.¹³

By 1879, the trustees had raised $28,228.09 from land sales. As ordered by the will and affirmed by the Supreme Court, the trustees were immediately to begin to make arrangements for the creation of a building or buildings (Kingdom of Hawaii, 1879a). Furthermore it was ruled that the sum in excess of $25,000 would remain under the discretion of the trustees and could not be claimed by heirs of the testator (Kingdom of Hawaii, 1880).

The Lunalilo Home: until 1900

The foundation stone for the first permanent facility of the Home was laid in April of 1881. The site that had been selected by the trustees was in Makiki overlooking Honolulu proper. During this ceremony, speeches were made by trustee Sanford Dole, Supreme Court Justices A.F. Judd

¹³ Princess Ruth Keelikolani was one exception. She was of the Kamehameha line: a half-sister to Alexander Liholiho and Lot Kamehameha. Princes Ruth was purported to be the richest woman in the kingdom. The lands that she bequeathed to Bernice Pauahi Bishop represented the bulk of what would become the Bishop Estate. Bishop Estate is the largest private land owner in the islands. In 1880, Princess Ruth bought 14,000 acres of the Kawela ahupuaa on Moloka'i for $2,750 (Honolulu Advertiser, 1940).
and McCully, and Hon. Simeon K. Kaai. Excerps from their speeches indicate the mood of the day.

The late King Lunalilo provided by his last will that after his aged father's death, his estate should be used to build and endow an institution on this Island to be devoted to the care of aboriginal Hawaiians as should need maintenance by reason of poverty, age or sickness. (Pacific Commercial Advertiser, 1881). [Excerpt of speech given by Dole].

... The principle characteristics of this chief were as follows: First, he had no sympathy with the ignorant follies of ancient times, its superstitions or its deceiving practice of medicine. Second, he was a gracious chief, he was accessible to the lowest native, he cared not for the pomp and varities of royalty. Third, his greatest work was this [the Lunalilo Home], which will preserve his name forever - his last will and testament. ... Lunalilo alone, up to this day has left his property for the Hawaiian race. ... But the aged and feeble Hawaiians of both sexes have a right to be here in this home which the royal heart has given out of his boundless love for his countrymen. (Pacific Commercial Advertiser, 1881). [Excerpt of speech given by A.F. Judd].

This King enjoyed the blessings of civilization, which were denied to his ancestors, the pagan kings and the chiefs of old, old times of our Islands. Those who well knew the late King, and the ancient history of that family, must acknowledge that none ever equalled him in deeds of generosity like this. Their history is crowded with deeds of a very different character. (Pacific Commercial Advertiser, 1881). [Excerpt of speech given by S.K. Kaai].

---

14 S. Dole's speech was given in the English language while the speeches of A.F. Judd and S.K. Kaai were originally delivered in the Hawaiian language. The Pacific Commercial Advertiser (1881) reproduced all text in the English language.
On this auspicious occasion, the speech makers were definitely attempting to distinguish between their enlightened modernity and the preceding "dark ages" of Native Hawaiian culture. Their modernity was distinctly western and an attack upon Native Hawaiian culture and practices: inclusive of health practices. Kaai's speech venerates especially the works of Alexander Liholiho and, of course, William Lunalilo: the only two to create institutional legacies for their people. But, we are told, Lunalilo is at the pinnacle because of this philanthropic project (see Pacific Commercial Advertiser, 1881).

The cornerstone was laid on Wilder Avenue between Pensacola and Piikoi streets. The building contract was awarded to E.B. Thomas for $28,310: the lowest bidder of six prospective contractors (Dole Collection, 1880). The stonework for the building was extracted from the government quarry at Punchbowl although the building also employed the use of other building materials.

Tenants were accepted into the facility while it was still undergoing construction in 1881. The construction was finally completed in April of 1883 (Pacific Commercial Advertiser, 1883). Its location, its history, and its novelty made it a constant focus of tabloids.

The estate enjoyed the prestige of its founder and the endorsement of the bourgeoisie. Despite this, the estate in 1883 was on tenuous financial footing. The estate was still
slowly auctioning off property to meet expenses and for investment purposes (see Dole Collection, 1885). By 1891, the estate was on firmer financial ground: "through their [the managing trustees] discrete management and prudent investments the value of the estate has advanced from a small sum to a very substantial amount" (Pacific Commerical Advertiser, 1891: 1).

The Institutional Climate: until 1900

A newspaper article describes the setting upon which the facility sat:

Fifty-five acres on Punchbowl and Makiki valley slopes were set aside for the home and sixteen of these acres were placed under cultivation. The home commenced its work in 1883, two years after the cornerstone had been laid and eight years after the death of the donor, the latter's father having enjoyed the income in the interim. The graceful building is constructed of rock from the very slopes upon which it is built. (Pacific Commercial Advertiser, 1911).

In its everyday operations, the institution was accepting tenants (often referred to as inmates) from throughout the kingdom. For those within the facility, this was respite from direct impoverishment. Also provided to them were periodic visits from medical practitioners. Tenants,

15 The trustees at this time included Mary Parker, Henry Waterhouse, and W.O. Smith. Smith was the managing trustee, following Sanford Dole in that post, which meant that he was in charge of the finances and correspondence with the Supreme Court and other government agencies.
however, were removed from the facility if they posed a health threat or were seriously ill.16

In 1886, the Lunalilo Home serviced twenty-two tenants: fifteen men and seven women. Of course, inmates, primarily elderly, were also dying. In two consecutive annual periods nine patients had died. Total admissions since its operation at the Makiki site were 83; the average age of inmates reported as 66.67 years. These admissions hailed from across the kingdom: "Hawaii furnished 19, 13 males, 6 females; Maui 7, 5 males and 2 females; Oahu 5, 4 males and 1 female; Molokai 3, 1 male and two females; Kauai, 2, males". (Hawaiian Gazette, 1887: 8).

In a report submitted by Henry Smith and Nathaniel Emerson to the Justices of the Supreme Court was the following statement:

Inmates, after residing some time at the Home, have been noticed to lose that healthy interest in themselves and their surroundings which at first seemed to operate as a useful stimulus to their bodily health. To remedy this, light work is recommended, and notice is taken of some creditable industrial efforts which have been made by several of them. (Hawaiian Gazette, 1887: 8).

16 Physicians were not a part of the institution per se; rather, they were contracted by the ensemble. Dr. Nathaniel Emerson was one of the first physicians to frequent the Home. In a letter from him to then Trustee Sanford B. Dole, Dr. Emerson recommends the removal of a tenant named Koloa (a woman) because she presents symptoms pointing to the onset of leprosy (Dole Collection, 1885).
The Home offered a comfortable respite within the reaches of the city of Honolulu and health care. But, what was noticed at the time was the debilitating effects of institutionalization. As an asylum, it encompassed the lives of its "inmates". In short, the Home exhibited many characteristics of "total institutions". But, it should be noted that there were many positive aspects to the experiences of the tenants as well. For example, in the years to come there would be a number of marriages between persons within the institution.

Every year an anniversary for the founding of the Home and honoring its founder was celebrated. This annual event would host tenants, trustees, citizens, and dignitaries (Hawaiian Gazette, 1889; Honolulu Advertiser, 1944c; Honolulu Advertiser, 1947).

**Lunalilo Home: 1900 - 1927**

The annexation of Hawaii by the United States had very little effect upon the Lunalilo Trust and the operation of the Home. The Home was nested within the trust, thus it was buffered from political-economic changes as long as capital ownership remained unscathed.

---

17 The term "total institution" was created by sociologist Erving Goffman as an ideal type by which the social control of "inmates" could be assessed (Goffman, 1961).
The estate was still involved in investment activities. In 1900, the trustees sold stock in C. Brewer and Company securing a $29,000 profit in ten years. The proceeds were then invested in real estate mortgages. The question that the trustees placed before the Supreme Court was whether they, the trustees, were entitled to a commission; and if so, at what rate? The justices decided that the trustees were entitled to a commission of 2.5% for "moneys realized from securities, investments, and from sales of personal property" (Territory of Hawaii, 1901).

In 1907, the Home began enjoying tax exempt status in recognition of its eleemosynary activities. But even with this distinction and its investment portfolio, the estate was operating on the margin. Bequests to the estate certainly helped in keeping the institution viable.

In general, though, the period between 1900 and 1924 was uneventful in terms of organizational changes. But changes would be just beyond the horizon. The ensemble's status was about to change in a number of ways.

First, the perception of the Home as a repository for Native Hawaiian cultural knowledge was emerging. It did, after all, concentrate elderly Native Hawaiians from all major islands into a single place. Roberts' (1926) monograph used several residents of the Lunalilo Home in her work on ancient Hawaiian music for the Hawaiian Folk-Lore Commission. This activity was taking place at a time when
the commodification of Hawaii in the image of a Westerner's "tropical paradise" was emerging and the thrust toward Americanization was conspicuous. Native Hawaiian culture was increasingly becoming viewed as archaic.

Second, Native Hawaiian groups were beginning to become interested in the facility. Civic clubs were surveying the facility and finding it unacceptable (Honolulu Advertiser, 1924a).

And third, the tenuous financial situation of the Home was now becoming public knowledge. The trustees acknowledged the dismal financial status as one prong in defense of the conflagration against the facility being aired in the media (Honolulu Advertiser, 1924b).

The intersection of these three considerations brought the Lunalilo Home back to the forefront of public discussion and State concern. By 1927 changes were in the making.

Reorganization: 1927 - 1954

In 1924 members of the Hawaiian Civic Club toured the Lunalilo Home facility and found the conditions to be less than satisfactory. They reported the following to the media.

Sanitary conditions at the home could be very greatly improved. The wards are very bare, the floors are badly in need of a coat of paint, and are quite rough in spots. The beds are very old, some of them have hardly a vestige of enamel left, and are black and rusty and look as though they might collapse at any moment. The mattresses are
lumpy and the whole place presents a dilapidated and poverty-stricken appearance. There are two elderly attendants upon whom revolve the entire care of the inmates.

The sick ward especially needs attention. On entering the ward, which is approached through a corridor, one is met by a very disagreeable odor of uncleanliness, which, in the opinion of your committee, could, by proper sanitation, be eliminated. In fact, in both the men's and women's wards there is a pronounced odor of uncleanliness.

The whole building is in need of repair. Since its erection, about 40 years ago, very little work has been done on the building, except patching here and there. The roof leaks, there should be new drains, and a good deal of the woodwork is rotting away. (Honolulu Advertiser, 1924a:1).

The report did not stop there. It pointed out the monotony of the fifty-eight (i.e., 40 men and 18 women) residents' diets and made general criticisms and recommendations for improvements. The report also noted that the Home received an appropriation of $200 per month from the City and County (Honolulu Advertiser, 1924a).\footnote{18}

One of the Home's trustees, E.A. Mott-Smith, replied three days later. In an open letter to the Hawaiian Civic Club and the public at large Mott-Smith called the charges highly exaggerated. He also provided a defense of the trustees' situation: attempting to make the Home the responsibility of the Native Hawaiian community at large.

The trust has been limited in what it can do by its funds, especially since high prices caused by the war. Someone has asked why not ask help from the ...
Welfare fund? Lunalilo when he made his will was looking to his own blood. His conception was a kingly one, not to be submerged in commercial charity. His people of the blood can, however, contribute to the trust without violation of its principle. To ask general support seems to be outside the purview of that principle. (Honolulu Advertiser, 1924b).

At the beginning of 1927, the media itself became a participant in the discussion over the Home.

Since the World War there has been a yearly struggle to maintain the upkeep of the Home. The prices of food has (sic) so advanced that many of the former luxuries had to be given up. The servant problem is perhaps the greatest that confronts the Home. The endowment has been so small the last eight years that the number of helpers had to be cut down. (Honolulu Advertiser, 1927a).

The Home and its surrounding Trust had now moved to the forefront of public interest. What were the conditions of the trust and the facility? How would the public and State respond, if at all? As it turned out, this public exposure acted as an impetus to spur various groups into action.

As early as May of 1927, the trustees were making serious plans for the immediate future. They were receiving tentative approval from the circuit court to sell their Makiki site, some of it subdivided into residential lots, and then to move to a site in Koko Head. The new site would be purchased with the help of the trustees of the Irene Ii Estate (Honolulu Advertiser, 1927b).
As the move was going through its final stages, the trustees named William P. Jarrett, a former delegate to congress and former manager of the Oahu Prison, to be the facility's manager. The Estate's trustees were also suggesting that some of the new Koko Head site could be used to raise produce, thereby reducing the cost of operation (Honolulu Star-Bulletin, 1927).

The Territorial legislature also began to become involved. The legislature began appropriating funds for the operation of the Home (Kamakahi, 1989b; Lunalilo Home File, n.d.). The logic employed for such appropriations was that without the Lunalilo Home, the residents would become full rather than partial wards of the State. Even though this went counter to the theme of universality, since the Home offered services to only Native Hawaiians, the logic of cost savings to the State prevailed. In 1927, the appropriation to the Home was $9,600; but in the next biennial sessions this amount would be increased to $24,000, reaching $60,000 in 1943 (Lunalilo Home File, n.d.).

The Home also received some supplementary funds from the City and County of Honolulu for the care, board and attendance of some patients (Honolulu Star-Bulletin, 1944). Private bequests and donations were also being received (Honolulu Star-Bulletin, 1942; Honolulu Advertiser, 1946a).

The 1945 annual report of the Estate inventory listed the following: "Bonds $169,000, cash $463.18, notes

151
$30,142.51, real estate about 2,820 acres, with improvements and ... corporate stocks" (Honolulu Advertiser, 1946b). The stock portfolio was comprised of mostly national companies: AT&T, American Tobacco, Caterpillar Tractor, Proctor and Gamble, Standard Oil of California, Union Carbide and Carbon and so on. In all, the Estate's stockholdings were worth upwards of $175,000. There also seemed to be a slight "changing of the guard" occurring with regard to trustees and management (see Honolulu Advertiser, 1946c, 1951; Honolulu Star-Bulletin, 1946, 1949a, 1949b, 1949c, 1951, 1954).

In general, the years since 1927, when the facility moved to Koko Head, were years of great improvement. The criticism which had acted as the impetus for change was successful in garnering assistance from community and government agencies. With consistent legislative appropriations, the Home was financially comfortable. In terms of operation, the facility was still offering custodial care to residents with periodic visits from contracted physicians.

Reorganization: 1955 to present

The year 1955 dropped a bombshell on the Home and its surrounding Trust. Territorial Attorney General Edward N. Sylva ruled that the facility could no longer receive appropriations from the legislature because the Home
restricted services to Native Hawaiians (Honolulu Star-Bulletin, 1955a). The theme of universality was finally evoked with regard to the Home. In the previous ten years, the facility had been appropriated $80,000 per biennium: which constituted half the Home's operating budget for the two year periods. The implications of the opinion were indeed serious.

The changing of the guard in the late 1940s and early 1950s had brought the Home and the Estate in the public's eye occasionally. But this story placed them in the forefront. Now, brief vignettes about the Home and estate's history and mission were printed (Honolulu Advertiser, 1955, 1957; Honolulu Star-Bulletin, 1955b, 1960).

It was noted that the Home's qualifications for residents were: (1) that the person was of Native Hawaiian ancestry and (2) that the person required the care available at the facility. The services included custodial care, weekly visits by a physician, and access to a contracted dentist. The trustees, which now included William Bishop Taylor, Napua Stevens Poire, and Lawrence M. Judd, had some

---

19 The actual written opinion could not be found in the microfilmed listing of Attorney General opinions located at the Hamilton Library of the University of Hawaii - Manoa. The opinion was rendered by Attorney General Edward N. Sylva when members of the House Finance Committee and Senate Ways and Means Committee asked for a ruling. It was reported that the actual opinion was not released by these committees or the AG's office. (Honolulu Star-Bulletin, 1955a).
political clout, but were selected to the posts by virtue of their relationship to the Home and/or the Native Hawaiian community. The positions were themselves non-lucrative given the relatively small value of the Estate.

Despite the Attorney General's opinion, the Territorial legislature decided to appropriate funds to the Home. It was reported that key legislative members had decided that "the only true way to settle the question would be in court" (Honolulu Advertiser, 1955). The legislature again appropriated $80,000 for the biennium, as it had done in the past. Again the argument was forwarded that without the Home and estate, its residents would become full wards of the Territory which would result in the government paying twice what it was doing now for the sixty or so tenants (Honolulu Advertiser, 1957). No court case regarding the issue would be pursued.

Through Statehood and the early 1960s, the debate continued to wage. The result, though was the same: an appropriation of $40,000 per year.\footnote{The legislature after statehood met every year instead of biennially which had been the case from the Kingdom through the Territorial times. So the amount appropriated was the same.} The legislative appropriations, however, were soon to cease.\footnote{After 1967, a direct appropriation to the Home could not be found (see Kamakahi, 1989b). This process was probably exacerbated by a Master's report which was critical of the Home (Honolulu Advertiser, 1966).}
such monies constituted half of the Home's operating budget, the estate realized that they were in dire straights.

The solution arrived upon by the trustees\textsuperscript{22} was the subdividing of the property upon which the Home sat. That parcel was twenty acres in size. With the withdrawal of the governmental appropriation, the estate trustees saw this alternative as the most viable means of securing a constant yearly income. As early as 1971, the estate was planning the project.

Fifteen of the twenty acres were subdivided: creating 85 homes available to the public on a leasehold basis. This meant that the outdoor space available to the residents shrunk dramatically. The estate, left to its own devises without government help, though, remained financially viable.

Since the early 1970s, the operation of the Home has not changed considerably. The major financial basis of the estate remained in its portfolio of stockholdings, supplemented by patient receipts, leases, rents, and donations. The Estate's fair market value in 1984 was reported at $5.6 million and the Home's annual operating expenses at roughly $190,000 (Kamakahi, 1989b; Lunalilo Home, 1986).

\textsuperscript{22} The trustees of the Home at this time were Napua Stevens Poire, George Ii Brown Jr., and J. Cline Mann.
Over time, the structuring of the health sector has incorporated the Home. Originally, the contours of the health sector left such care facilities as the Lunalilo Home relatively unregulated. However, the political-economy of health has continued to incorporate such ensembles. At present, the Lunalilo Home is listed as a care facility. The Hawaii State Department of Health oversees the Home and such ensembles in the health sector periphery. The Home remains on the periphery of the health service sector as it had been since its inception. Medications are dispensed within the facility; but its main function is to offer custodial care to residents. The capacity of the facility is sixty-five persons: a limit established by the Department of Health (Honolulu Star-Bulletin, 1971).

Since the 1950s the facility has disappeared into relative anonymity. Unlike certain periods, namely the 1880s, the 1920s, and the 1950s, the estate and Home has received very little attention by the media, the community, and researchers.\(^{23}\)

\(^{23}\) The only previous studies of the Lunalilo Home in recent times has been that of Kauka and Mokuau (1977) and Kamakahi (1989b). The former was an M.S.W. thesis on characteristics and attitudes of residents. The latter was a short article which included a brief section on the "highlights" of the institution's evolution.
Lunalilo Home in Historical Context

Since its creation in the will and codicil of William C. Lunalilo, the Home has enjoyed a checkered history. While the Home has always been on the periphery of health care per se, the circumstances surrounding it have occasionally affected changes within it.

Governmental Relations

As an eleemosynary trust, the estate has always enjoyed a relationship with government agencies. The most intimate relationship has existed between the estate and the Supreme Court. This was especially the case since the will assigned the Supreme Court the task of appointing trustees and overseeing the Trust's management. It is little wonder, then, that trustees selected were often persons with political clout in their own right: examples include Sanford B. Dole, who would later became President of the Provisional Government and Republic of Hawaii as well as the first appointed Governor of the Territory; John Mott-Smith, dentist, newspaper editor, and Minister of Finance under Lot Kamehameha and Liliuokalani; Edwin O. Hall, newspaper editor, businessman, Minister of Interior under Lunalilo, as well as President of the Board of Health; Lawrence M. Judd, Territorial Senator as well as Territorial Governor. The prestige of the position of Lunalilo Estate trustee waned
over time: its novelty, its mission, and its finances as well faded into the woodwork.

Unlike the core of the medical sector which was being explicitly revamped in the image of the Western template, the periphery of the health sector remained virtually untouched. In contradistinction to Queen's Hospital which was immediately influenced to sever its ties to the government, the Lunalilo Home would become more financially dependent upon the government. In 1907 it was awarded tax exempt status and in 1927 government appropriations to the facility were begun. This latter action being contrary to the theme of universality imposed upon Queen's Hospital.24

Once this violation of universality became a legal issue, it was still twelve years before the legislature actually ceased appropriating money directly to the facility. Rather than a separation of private and public sectors, the development of the facility showed the opposite tendency. The government was supplementing the care of residents in the Home. And, the interaction of the Home and the political-economic environment seemed to suggest that the custodial care of indigents was a right of citizenship; but, that any higher level of care for the citizenry was a

24 Queen's Hospital upon Annexation was immediately required to universalize its services when public monies were involved. The Lunalilo Home was never required to do so to receive its appropriations.
Discourse About the Home

While the function of the home has been relatively constant over time, the discourse about the home has been uneven and changing.

At its inception, the project was lauded as the first philanthropic enterprise emanating from the royal family. Its novelty and its "noble mission" were praised as one example of Lunalilo's, and the Hawaiian Nation's, inception into modernity. It reflected the template which was diffusing throughout the kingdom: specifically, that of the institutional means of addressing social and health issues. The novelty of the trust instrument would serve as somewhat of an exemplar as well: to be followed by the Dowager Queen Emma, in the Queen Emma Trust; Bernice Pauahi Bishop, in the Bishop Estate; Liliuokalani, in the Liliuokalani Trust. The selling of real property for cash was, however, one aspect that would be discarded by later trustors.

In the early 1900s, the focus of the discourse changed to include the emphasis of the Home as a repository for Native Hawaiian culture. Moving into the Territorial period, the transformation toward Americanization was occurring in the Hawaiian society at large. The Home, buffered by the parameters of the trust, was being seen as a
niche of antiquity. This spurred a push for greater
criticism of the inadequacies within the facility and
increased involvement by community and government agencies.

By the late 1950s the themes of universality and the
separation of public and private sectors were being invoked.
Ethnic privilege and government "charity" were not to be
tolerated anymore. By the early 1970s, the trust was left
to its own devises.

The Role of Philanthropy

The Lunalilo Trust was the foundation upon which the
Lunalilo Home was created; it encompassed and defined the
Home's parameters. The will and codicil directed the
ensemble's selection of policy makers: that is, there would
be three trustees who would be appointed by a majority of
the Supreme Court and remain under the direction of said
court. The documents specified how funds were to raised
initially: i.e., through the sale, by auction, of real
properties until $25,000 in cash was secured for the
building of the facility. It was pre-determined that the
Home would be located upon the island of Oahu. And, the
trust beneficiaries would have to meet two criteria: (1)
they would have to be of aboriginal blood or extraction
(i.e., Native Hawaiian) and (2) they would have to be
destitute and/or infirm. A preference for the elderly was
also stated.
The structuring of the trust as William Lunalilo did would very much influence its trajectory. By selling the bulk of his real property immediately for cash, the estate was disposing of an important means of capital and equity that it could have drawn upon in the future. Although Lunalilo could not have foreseen the dramatic increases in property values that would take place in coming years, his directions undercut any firm basis for operating the Home indefinitely. Subsequent royal family trust projects were land based: e.g., the Queen Emma Trust, the Bishop Estate, the Liliuokalani Trust. The Lunalilo Estate, instead, would be run primarily off of proceeds of a stock portfolio, bond holdings, private donations, government appropriations, and patient receipts.

The target population, infirm Native Hawaiians, would also affect the Home's operation. First of all, it would be contrary to the theme of universality which would dominate within the Territorial period: the will was specific in explicating those of aboriginal blood rather than the more ambiguous term "Hawaiians". Secondly, this would ostensibly eliminate any sort of market orientation on the part of the trust: the specification of residents being destitute and infirm was stated. With such directions, the institution would remain on the fringes of the health sector: providing custodial care and contracting health practitioners on a regular basis.
The dictates of the will of Lunalilo were such that they presented a virtual "stranglehold" on the Home's operation. Since the Home was encompassed by the trust estate, the parameters of the latter determined the operation of the former. The Home as beneficiary, in other words, could not exist without the trust being viable. The trust also acted as a buffer to the Home with regard to external influences. But at the same time the trust would have little discretion in redefining its own project; its project had been "set in stone" in the will of 1871. The trustees, then, were functionaries rather than policy makers per se. The trust, then, may have been too inflexible for its own future viability.

It is, however, important to note that neither has the trust in its many years of existence, attempted to create constructive funding alternatives for the Home. Private donations and bequests have been sporadic and community chest projects ephemeral. In addition, the Home and the trust estate has continually opted to take a low profile unless spurred on (in defense) by some external group. The orientations of trustees to be caretakers rather than advocates of the estate, the Home, and its residents is worth noting. While the trust's relationship to the Home was pre-ordained, the relationship of the trust and Home to other agencies, whether Native Hawaiian groups or the government, is not.

162
CHAPTER 5
THE KAPIOLANI MATERNITY HOME

The girl queen, who has been cut in two by the slaughterhouse knife, is glued together, emitting a slight fragrance of desolation. She survives herself, just as the child survived the malediction that killed him. (Sartre, 1963: 113).

This chapter discusses the trajectory of the Kapiolani Maternity Home from its genesis in the Hoola a me Hoʻoulu Lahui of the Kalakaua reign. The Home was unique in a number of regards. First it represented one prong of the Kalakauas' attempt to deal with the declining population of Native Hawaiians in the kingdom. Second, the Home was established and dominated in its early management by women. And third, in comparison to the other Crown-Based Health Ensembles (CBHEs), the Kapiolani Home was least endowed by the mechanism of royal philanthropy.

The original focus of the Kapiolani Maternity Home was to provide adequate surroundings for women during the birthing process. The Home's founders believed that childbirthing fell into the purview of western physicians. In other words, they had accepted the "clinical gaze"²

¹ The name of the society is variously recorded in the media and documents of the day. Literally, hooulu means to propagate; hoola to give life to; and lahui refers to a collectivity (see Pukui and Elbert, 1971).

² Foucault (1973) refers to the clinical gaze as the adoption of a discourse which considers the human body to be
orientation toward the body. The medicalization of birth was emphasized within a backdrop of foreign diseases and institutional means of treatment.

Organization: Charter of Incorporation, 1890 - 1891

In December of 1891, the Kapiolani Maternity Home of the Hooulu A Hoola Lahui Society was granted it's charter of incorporation by the Kingdom government. The charter document itself provided minimal information regarding the template upon which the organization would be based. It's stated purpose was to provide women with "proper care and treatment during the period of childbirth" (Kapiolani Home, n.d.; Kamakahī, 1989b).

The specifics of management were to be handled by the encompassing Hooulu A Hoola Lahui Society whose members included: Queen Dowager Kapiolani, Mrs. Alex Mackintosh, Mrs. Al Haalelea, Mrs. H.R. MacFarlane, Mrs. E.S. Cunha, Mrs. J.I. Dowsett, Mrs. Sam Parker, Mrs. A. De Souza Canavarro, Mrs. A. Fuller and Mrs. S.I. Wilcox (Yardley and

the object of scrutiny for a small group of "trained" specialists: i.e., physicians/surgeons. The clinical gaze is seen as a form of power/discourse in which the gazers (physicians) assume power and control over the objects of the gaze (patients) by means of specialized training and esoteric language. In essence, the patient in such a relationship is objectified.
Rogers, 1984). These people, all women, were tied to the local bourgeoisie financially and/or politically.3

**Group-in-Fusion: Hooulu A Hoola Lahui, 1874 - 1890**

David Kalakaua was the second elected monarch of the Hawaiian Kingdom. His predecessor, William C. Lunalilo, had served in that capacity for a little over two years until his death. The second interregnum, unlike the first, was a hotly contested affair. The voting community and the Native Hawaiian community were quite divided. Kalakaua, however, mustered the necessary support within the legislature to become king.4

The ascension of Kalakaua to the throne, and Lunalilo before him, marked the end of the Kamehameha Dynasty. Kalakaua's genealogy could not be traced through Kamehameha I, although his pedigree was quite legitimate in its own right.5 He, like the previous four sovereigns, had attended the Royal School and thus been exposed there to

---

3 Kapiolani, of course, was the Queen consort; Mrs. Mackintosh was the directress of the Strangers' Friend Society; Mrs. MacFarlane's husband was Denmark's foreign Consul; Mrs. Canavarro's spouse was the Portuguese Consul; and so on.

4 After the election, supporters of Dowager Queen Emma stormed the legislature in which she had only mustered six of forty-five votes. The riotous crowd was only dispersed when foreign marines, British and American, were landed (see Kuykendall, 1967).

5 Kalakaua's pedigree was traced to Keaweaheulu who was an uncle and supporter of Kamehameha I and "one of the four great chiefs of Kona" (Day, 1984: 73).
both Native Hawaiian and Western weltanschauung. In their youthful maturity, the king and his siblings were recognized for their musical compositions which set about merging Native Hawaiian lyrics within a western musical form.⁶

While there were many issues upon which Kalakaua's rise to the throne hinged, among the most important were his views in favor of a Reciprocity Treaty with the United States and the formation of the "Hooulu a me Hoola Lahui" theme. The former acted to appease the ever-growing influence of the sugar plantation industry; the latter to address the continuing decline in the Native Hawaiian population.

**Hooulu Lahui and the Issue of Leprosy**

The Hooulu Lahui was one of the creations of Kalakaua's reign. It's amorphous purpose was to increase and preserve the nation, particularly the Native Hawaiian "race" (Pukui and Elbert, 1971; Yardley and Rogers, 1984; Kamakahi, 1989). The movement of the Lahui was organized mostly through the efforts of Kalakaua's spouse, Queen Kapiolani.

Kapiolani was the niece and the namesake of the chiefess that had defied the goddess Pele. She was also the

---

⁶ Specifically artistic in this regard were David Kalakaua, his sisters, Liliuokalani and Likelike, and his brother Leleiohoku (see Kanahele, 1979). See Kamakahi and Robillard (1991) regarding the incorporation of Native Hawaiian chants into the political-economy of private appropriation.
granddaughter of the last ali'i nui of Kauai: Kaumualii. Before marrying Kalakaua, she had previously married Bennett Namakaeha and served as the governess to Prince Albert: the son of Alexander Liholiho (Kamehameha IV) and Queen Emma who had died at the age of four. Kapiolani married David Kalakaua in 1863.

Among the major activities of the Hooulu Lahui was the handling of certain aspects of the leprosy problem as they existed within the Kingdom. Leprosy had been a major health issue within the kingdom since the 1860s. By 1874, the year in which Kalakaua became king, the census of lepers in Kalaupapa, as well as admissions and deaths, were reaching their highest levels. They would remain high: the Kalaupapa census ranged between 565 and 1174 during his tenure (see Schmitt, 1977: 72).

Unlike the other infectious diseases which had been diffused throughout the kingdom, leprosy did not take it's toll immediately. It was a degenerative disease: taking some time before its full effects were nascent. Prior to death, the afflicted person could expect social stigma, separation from family and loved ones, and physical deterioration. In short, the effects were prolonged over a period of years. ⁷

⁷ There are several good books referring to the impact of leprosy in kingdom Hawaii. (See Daws (1973), Gugelyck and Bloombaum (1979), and Hanley and Bushnell (1980))

167
Previous administrations had dealt with the implications of the affliction on an ad hoc basis. The groundwork for the isolation of lepers was completed in 1866 when Kalaupapa was designated as the leper colony of the kingdom. The government fully expected that the colony would be largely self-sufficient. But even as early as 1868, the template was seen as inadequate:

... the terrible disease which afflicts the lepers seems to cause among them as great a change in their moral and mental organization as in their physical constitution: so far from aiding and assisting their weaker brethren, the strong took possession of everything, devoured and destroyed the large quantity of food on the lands, and altogether refused to replant anything. (Board of Health, 1868: 2).

In the next few years, a slew of policies were passed by the Kingdom government. Such acts included: the building of leperas on each island (Kingdom of Hawaii, 1869a), requiring lepers to provide a certain amount of labor (Kingdom of Hawaii, 1869b), giving great latitude to the Board of Health to survey and to make rules and regulations with regard to leprosy (Kingdom of Hawaii, 1869c; 1870a), to restrict access to Kalaupapa (Kingdom of Hawaii, 1870b), to require physicians and others to report infectious and communicable diseases (Kingdom of Hawaii, 1869d), and to deny the right of marriage to lepers to the "healthy" (see Board of Health, 1946: chapters 42, 43, and 301).
The trip to the leper settlement at Kalawao on Kalaupapa was seen basically as a life sentence. The stigma attached to the affliction of leprosy resulted in the forced separations of family members (see Gugelyck and Bloombaum, 1979). This breaking of the family unit as a result of the disease became a focal point for the Hooulu Lahui; the breaking of the family contributed to the decimation of the Native Hawaiian population.

The Lahui itself became involved initially with maternity care indirectly through the Franciscan nuns doing work on Kalaupapa. The nuns, under the guidance of Mother Marianne, proposed to transport those children born in the leper settlement without the afflictions themselves to Honolulu to be cared for. The nuns were successful in lobbying the Board of Health as well as the sovereigns and were bolstered by Walter Gibson's cooperation in this endeavor. The result was the Kapiolani Home For Girls, the Offspring of Leper Parents. Children sent there were raised in the confines of the Home or discharged to receptive relatives (Hanley and Bushnell, 1980: 224).

The Kapiolani Home For Girls was dedicated in 1885 at its site in Kakaako, Oahu. In a lengthy speech, Walter M. Gibson, then President of the Board of Health, both praised the government and the project, while condemning the former in reference to the circumstances of those born in the settlement.
The Government now expends in the care and promotion of the health of the people at least one-tenth of the annual revenues on the Kingdom. I cannot recall to mind any other country in the civilized world that can, in comparison, make such an unhappy statement, and yet one which is so much to the credit of the humanity of the nation. (Gibson, 1885:12).

It was felt by all who have considered the matter to be almost an outrage that young children especially girls only suspected on the ground of heredity of being tainted and yet giving no sign of this disease, but rather the evidence of being qualified to acquitted themselves well in the career of life, should be doomed to lose their opportunities, and be forced to associate with those only in whom the malady had pronounced itself. (Gibson, 1885: 13-14).

The Kapiolani Home was instigated by the Franciscan nuns. Its primary interest lay in the "rescue" of non-leperous female infants from leper's existence. The transition from children to childbirth itself was made the focus of the Kapiolani Maternity Home.

The Kapiolani Maternity Home

The Kapiolani Maternity Home of the Hooulu Lahui was a project initiated within the royal family and propagated by the "society women" of the day. Uncharacteristically for

---

8 Humanitarian discourse was common in public statements of the time. Such an orientation served as motivation for the creation of the institutional separation for the afflicted. Talmadge (1989) describes the humanitarian versus social control orientations of the Oahu Insane Asylum over time. Kamakahi (n.d.), however, argues that institutionalized treatment represents social control of various degrees irrespective of the discourse employed.
the times, this enterprise was created, organized, and administered by women.

The facility offered Native Hawaiian women the opportunity to experience the childbirthing process amidst sanitary surroundings and under the auspices of modern medical care (see Yardley and Rogers, 1984). The Maternity Home acted as yet another institutional means of creating and addressing health issues, but the actual medical expertise was external to the institution itself. The facility was established to deal with "women's needs" but was still subordinate to external, societal male dominance.

Institutionalization: Operations, 1890 - 1899

The Kapiolani Maternity Home was dedicated in June of 1890. The facility was located on the grounds of the former residence of Princess Kekaulike called "Ululani". The grounds had previously been bequeathed to the Princess' sons: David Kawananakoa and Jonah Kuhio Kalanianaole (Yardley and Rogers, 1984: 1). Within a few years, they, in turn, turned the grounds over to the Kapiolani Maternity Home for the price of one dollar with the provision that the property only be used for the Home's stated purpose (Provisional Government, 1894).9

9 One interpretation of this act refers to it as "probably the largest single gift of the royal family to the maternity home" (Honolulu Star-Bulletin, 1940).
The Maternity Home was situated at the corner of Beretania and Makiki Streets. As such, the facility was in close proximity to downtown Honolulu. The building was "fitted up in convenient manner" (Hawaiian Gazette, 1890). There were five bedrooms: each furnished by a different family or group\textsuperscript{10} (Pacific Commercial Advertiser, 1890a).

The facility was first opened to the general public amidst pomp and circumstance on the afternoon of June 14th, 1890. King David Kalakaua and Queen Kapiolani along with several dignitaries including the Princess Liliuokalani attended the festivities. The mood was enhanced by the presence of the Royal Hawaiian Band under the direction of Henry Berger.\textsuperscript{11}

The officers of the Hooulu Lahui included: Queen Kapiolani, president; Mrs. A. de Souza Canavarro, vice-president; Mrs. J.I. Dowsett, treasurer; and Mrs. C.H. Ulukau, secretary. Selected from the membership to serve as the Home's "board of lady managers" were: Mrs. A. Mackintosh, president; Mrs. A. Hanalelea, vice-president;

\textsuperscript{10} These included one furnished room each by Mrs. T.R. Foster, the Widemann family and the Robinson family; Mrs. Canavarro and Mrs. J.I. Dowsett; and Mrs. S. Parker, Mrs. T.W. Everett, and Mrs. E.P. Low.

\textsuperscript{11} Berger was the most well known of the directors of the Royal Hawaiian Band. He was also it's conductor and served as composer and arranger as well. Of special note was his composition "Hymn to Kamehameha" which later became known as "Hawaii Pono'i" with lyrics written by David Kalakaua. Hawaii Pono'i became the Kingdom of Hawaii's national anthem in 1876. (Kanahele, 1979).
Mrs. H.R. Macfarlane, treasurer; and Mrs. E.S. Cunha, secretary. Others specifically listed were Mrs. J.I. Dowsett, Mrs. S. Parker, Mrs. A. Fuller, and Mrs. W.L. Wilcox (Pacific Commercial Advertiser, 1890a). The Lahui was the canopy under which the maternity home's officers were selected. Later these groups would take the form of the Board of Trustees and the Managers of the facility.

Although the Home opened in 1890, it was not until a year later that it was formerly chartered by the Kingdom government. The Home served to medicalize the childbirthing process within the confines of a "homey" environment. When needed, a physician was brought over by horse and carriage from the Queen's Hospital for the actual child delivery. The Maternity Home was only a setting for medical treatment; but its staff was largely ancillary.

The first nine years of the Maternity Home's operation were quite uneventful. While the facility opened its doors to the benefit of native Hawaiian women and people of other ethnic (backgrounds), the latter for a fee. Few took advantage of the offer (Honolulu Advertiser, 1959). The Home stood as a specialized facility for the propagation of the Native Hawaiian population and not as a medical facility per se.
The Death of Queen Kapiolani

Queen Kapiolani died just prior to the turn of the century and the change in Hawaii's official status from an independent Republic into a Territory of the United States. Through the nine years since the establishment of the Maternity Home, Kapiolani had remained involved as president of the Hooulu Iahui and as the institution's namesake.

A year prior to her death, she drew up an agreement with her nephews, David Kawananakoa and Jonah Kuhio Kalanianaole. In that agreement dated February 10, 1898, Kapiolani conveyed to her nephews "one hundred and twenty four separate parcels of real estate ... and all her personal property including bonds and stocks"\(^{12}\) (Territory of Hawaii, 1907: 497). In return Kawananakoa and Kuhio, who were both given the status of "princes of the realm" by Kalakaua's royal decree\(^{13}\), were to provide a monthly allowance to the Queen dowager of $1000 for life and assume her debts and obligations.

On the same day, in a separate agreement between the parties, a provision was made for the transfer of money to the Kapiolani Maternity Home. Kapiolani proposed the

\(^{12}\) One newspaper article reports Kapiolani's bequest to her nephews in real property to amount to only $15,000 (Honolulu Star-Bulletin, 1940), but reports no value for her other personal property. However, given the conditions of the agreement, it seems unlikely that the estate, in toto, would be anywhere near that emaciated.

\(^{13}\) Neither the title nor the status of the royal decree were inheritable (Day, 1984: 73).
transfer of $10,000 as a gift to the Home, the amount to be garnered from the lands conveyed to her nephews.
Kawananakoa and Kuhio agreed to pay the sum in $100 monthly increments (Territory of Hawaii, 1907).

The Home, which operated on tenuous financing, attempted to receive the immediate benefits of the money by establishing a lien on certain real properties. They placed their case before the Court of Land Registration and then brought it before the Territorial Supreme Court. The high court ruled that the donation to the facility was not sufficient in creating a lien on such property (Territory of Hawaii, 1907). Ironically, during this period of time Kawananakoa was president of the Lahui.

The gift, in whatever increments allotted, was a welcome financial boost to the struggling facility. At this time, the Home occupied a place on the margin of local and medical interest.

It is important to note that this form of philanthropy on the part of Queen Kapiolani, the small, incremental cash gift, was perhaps the feeblest form in terms of control of the receiving agency and its project.

Reorganizations: Redefining the project, 1899 - 1948

Within the span of some fifty years, the Kapiolani Maternity Home would undergo three periods of reorganization. Each successive reorganization would bring
the corporation closer into the core of technological medicine - always, though, remaining within the discourse of maternal care and childbirthing.

**Toward Universality, 1899 - 1922**

The Hooulu Lahui was a creation of the Kalakaua reign dedicated to the growth and propagation of the Native Hawaiian population. Queen, and then Queen dowager, Kapiolani had served as the group's president until her death on June 24, 1899. After her demise, one of her nephews, David Kawananakoa, would succeed her to that position; followed, in turn, by Kuhio, Kawananakoa's brother.

Concerns with pedigree overrode the predominantly female dominance of the organization. Kawananakoa and Kuhio had been and were chief benefactors of the Home and served in the Lahui as legacies of the Kalakaua dynasty. They had been involved in the Lahui and the Home through Kapiolani: who had been their guardian after their own mother's death.

David Kawananakoa and Jonah Kuhio Kalanianaole were two of three sons of high chief David Piikoi and Kinoiki Kekaulike. Their brother, Edward Keliihonua, died in 1887. They were cousins of Kalakaua and Liliuokalani (Day, 1984: 64). Though brothers, Kawananakoa and Kuhio opposed each other in the arena of Territorial politics: Kawananakoa as a Democrat and Kuhio as a Republican.
Kawanakoa served as president of the Lahui from 1899 through 1908. His term ended at his death. He was succeeded by Kuhio: who had travelled extensively and would serve as the Territory's delegate to Congress from 1902 until his own death in 1922.

During their combined tenure, a number of changes were made in the corporation's policy. The first change, occurring in 1900 was the appointment of the Home's first physician: Dr. Arthur C. Hodgins (Yardley and Rogers, 1984). This metaphorically changed the function of the facility from a maternal setting to a facility for medical practice.

The second change was the Home's move from it's original building, the former residence of Princess Kekaulike, to an adjacent building. This new facility was a more spacious, two-story structure purchased from August Dreier. With this move, the facility for the first time asked for renumeration for its services from those who availed themselves to them; it was experiencing financial difficulty. Perhaps, more significantly, the Home altered it's motto to change the term "race" to "human race" (Yardley and Rogers, 1984: 6). Initially, of course, it

---

14 Dr. Hodgins does not seem to have been on staff with the facility. It was probably an informal contractual agreement between the Home and the physician. The first staff physician would not be hired for four decades.

15 Note the incorporation of universalistic criteria occurred concomitant with a market-orientation.
was understood that the facility's purpose was to serve the Native Hawaiian population.

And third, the Home began the purposeful training of nurses. The first graduates of the nursing school, five in number, were graduated in 1923. Despite the Home's financial tightrope walk, it continued to expand the niche of maternal services within Hawaii's health sector.

These policy movements by the Home set the foundation for the medicalization of women's health, inclusive of the childbirthing process, within the facility. A small, but expanding, market orientation toward health services within the corporation was becoming manifest.

**Building Corporate Infrastructure, 1922 - 1928**

With the death of Jonah Kuhio Kalanianaole in January of 1922, his wife, Elizabeth Kahanu Kaauwai assumed his position. They had been married since 1896, she being the daughter of a chief of Kauai (Day, 1984). Later, she would remarry and become Mrs. J. Frank Woods.

The Board and Officers in 1922 were entirely female and represented, for the most part, Hawaii's local aristocracy as had been the case since it's inception. Officers and Board members were selected among those paying a dollar initiation fee and the same amount for annual dues (Yardley and Rogers, 1984).
The forte of the facility was, of course, childbirthing as well as simple neo-natal and maternal care. In 1922, the average stay was 12 to 14 days. Each stay cost the Home about $89. If complications arose, physicians could be transported from Queen's Hospital. (Yardley and Rogers, 1984). Both the average length of stay and the cost per patient day seem to be roughly the same as that reported by Queen's Hospital for that year (see Schmitt, 1977: 68).

During this period, the Home's sights were already set upon the creation of a medical facility with physicians on staff; but not necessarily confined exclusively to the role of only maternal care. Discussions with the Medical Society were arranged to evaluate the Home's options.

In Honolulu proper, Queen's Hospital dominated the hospital sector. Other facilities existing at the time included Kuakini Hospital (Japanese Hospital), Tripler Army Hospital, Kauikeolani Children's Hospital, Shriner's Orthopedic Hospital, with St. Francis Hospital's establishment occurring in vivo (see Nebelung and Schmitt, 1948). Each of these facilities were better equipped and staffed than the Kapiolani Maternity Home. As such, the Home was advised to either upgrade their status as a maternity facility or be banished into maternal care obscurity. They would not, it was thought, be able to

---

16 This is despite that fact that Queen's Hospital handled a much larger population and a much more heterogenous battery of afflictions.
compete with already established facilities as a general hospital.

The dilemma facing the Home's policy makers was whether the already debt-ridden corporation should dissolve, remain as it had been operating on the medical periphery, or to attempt to enter the hospital sector of Hawaii. They chose to do the latter. Having done so, the next set of decisions facing the Home was how to enter the hospital sector and how to finance such a move.

The hospital sector had developed in such a way that Queen's Hospital represented the hub of tertiary medical services (see Chapter 3). For the most part, other medical facilities focussed upon specific (sub)populations. Kuakini Hospital served the Japanese Community; Tripler Hospital catered to military personnel and dependants; Kauikeolani Hospital concentrated upon the care of children, and so on. The advice from the medical community was for Kapiolani Home to focus upon the medical care of women; thus providing continuity with it's institutional history and defining it's own unique (sub)population of interest and area of expertise. Obviously, Queen's Hospital dominated the resources of the Territory's health resources and was firmly established there. This conception and the parameters of the original charter acted as constraints to possible options.
In the following years, the Home was to concentrate upon the securing of funds and deciding on options for the prospective hospital. During such time, properties were bought and sold, the Board appointed its first men to serve on the Advisory Board Committee, and actual plans and construction were taking place (Yardley and Rogers, 1984).

The Home was now poised to enter the hospital sector of Hawaii. Concomitantly, it entered into the health care market orientation as well.

A Women's Hospital, 1929 - 1948

The change in status from a Home to a hospital was an important one for the organization and engendered a number of ramifications. The Home could no longer just provide ancillary care. As a hospital it would be obliged, if it wanted to be taken seriously by the medical community, benefactors, and financial lenders, the objects and instruments of technological medicine.

The new facility accomplished this architecturally. The opening of the facility was treated as a media event by the Honolulu Star-Bulletin newspaper (1929a,b,c,d,e,f). A series of articles were printed in the tabloid's March 26th issue covering various aspects of the new 50-bed facility. The project's cost was estimated at $250,000: $153,000 for

---

17 Foucault (1972) speaks of panoply - referring to how power relations are often objectified concretely in architecture.
the building itself and $100,000 "spent on equipping the facility" (Honolulu Star-Bulletin, 1929c). On the occasion, the royal history of the Home was also being lauded as well as it's focus upon Native Hawaiians. Mr. Young, the president of the engineering company which built the facility, said on the building's debut: "Started by Hawaiian royalty for the Hawaiian race ... I thought it fitting and proper that only Hawaiians be employed to erect this structure" (Honolulu Star-Bulletin, 1929c).

A physician, Dr. A.G. Hodgins, was appointed as Chairman of the Advisory Board of Physicians. This Board would appoint the house doctors "who would be called alphabetically on a volunteer and rotating basis" (Yardley and Rogers, 1984: 24).18

The Home completed the transformation to a hospital in name as it had already in deed in 1931. A charter amendment changed the corporation's name from the Kapiolani Maternity Home to the Kapiolani Maternity and Gynecological Hospital.

Financial woes were still a matter of concern for the facility though. The transition into the hospital sector was quite costly. As part of the hospital's attempt to reduce their indebtedness, they again began fundraising efforts. In discussions with the Public Health Committee of the Chamber of Commerce, the officers of the hospital were

---

18 Apparently, these were not staff doctors, but rather physicians which used the facility.
referring to the facility as a "community project" growing to "better serve the increased need of an expanded community" (Yardley and Rogers, 1984: 28).

With community assistance, the hospital was finally able to get onto more solid financial footing (Honolulu Star-Bulletin, 1937). The search for monies for the facility did, however, surface in a series of court battles with the Mary E. Foster Estate. Between 1932 and 1936, the conflict between the estate and the hospital reached the Territorial Supreme Court twice, and the calendars of the 9th U.S. District Court and the Territorial Circuit Court of Equity. The dispute revolved around $50,000 that Foster had left to the hospital in her will. Specifically, the question was whether a $25,000 donation paid prior to her death constituted a portion of the amount bequeathed to the organization in her will. The Territorial Supreme Court in 1936 ruled that the prior donation was independent of the will bequest.20 Foster had specified that either five

---

19 Mary E. Foster was the daughter of island shipbuilder James Robinson. She married Thomas Foster, one of the organizers of the Inter-Island Steam Navigation Company. Foster was known for her philanthropic efforts with regard to Leahi Hospital, the creation of Foster Gardens, and to the Kapiolani Hospital. Prior to her death she had contributed upward of $30,000 to the latter (see Day, 1984; Territory of Hawaii, 1932; 1936).

20 Yardley and Rogers (1984), however, state that there was, in fact, an agreement between Foster and the Hospital regarding the $25,000 as an advance of the will bequest. And they report the events as uncontested.
beds or a ward be set aside for those who could not afford to pay for the Hospital's services: i.e., as charity beds.

The policy of expansion was continuing for the facility. Nursing quarters were improved; and in 1940, the first resident physician was appointed. The Territory had begun allotting funds to the facility for charity work. And, the hospital set its sights on the further expansion of the facility in the form of an additional wing.

Nineteen-forty also marked the corporation's fiftieth jubilee. For that occasion, special fund raising activities were enacted. A newspaper article noting the events read: "Queen Kapiolani's great gift to the maternity hospital which bears her name was her interest and moral support rather than her money" (Honolulu Star-Bulletin, 1940).

Early in the 1940s, the first Financial Advisory Board was created by the institution. Its members were Alan S. Davis, J. Pratt Cooke, and Cyril Damon. The financial situation of the organization had been a constant cause for concern in its first fifty years of existence.

By 1948, the institution had successfully carved out its niche in the health sector: more specifically, in the tertiary sector of hospital care. Furthermore, the intrusion of males into the operation of the facility was becoming more apparent. Physicians were males, the finance committee were males, and males were also populating the upper echelons of the corporation. In contrast, the
facility had expanded from just childbirthing per se to the "clinical gaze" of the female body. 21

The hospital's expansion included an X-ray Department as well as a sixty bed addition to the facility funded by a federal grant, community contributions, and hospital funds. By 1948, the average patient stay was approximately five days (Yardley and Rogers, 1984), as opposed to eight days for other hospitals in Hawaii (see Schmitt, 1977: 69). The growth of the hospital, though, would not end here.

Institutionalization: Women's Medical Care, 1949 - 1970

The Territory and various other agencies were surveying the hospital sector in Hawaii in accordance with the Hill-Burton Act (see Bolles, 1947; Nebelung and Schmitt, 1948; Weinerman, 1952). By this time, Kapiolani Hospital had a secure hold on the sphere of medical care for women. In fact, the hospital sector in Honolulu had not changed in some two decades and would remain virtually the same for yet another ten years. This stabilization in the sector coupled with Kapiolani's domination of women's medical care meant little direct competition from the "market".

The motivation for expansion at this time was to solidify the infrastructure which the facility had been

21 The irony of the situation was that the increasing infiltration of males was occurring as the hospital was increasing its expertise to issues beyond maternity itself to the comprehensive care of women.
creating at a brisk pace for some twenty years. Financially, the hospital was on solid footing. The surveys of hospitals in Hawaii were in agreement that the hospital was "legitimate" and an important part of the Territory's health system (see Bolles, 1947; Nebelung and Schmitt, 1948; Weinerman, 1952). The existence of health insurance also acted to reassure the facility of payment for services rendered.

On the medical front in 1949, a two-year residency program for the hospital was approved by the American Medical Association. This meant that the facility was "advanced enough" to warrant a partial role as a teaching hospital. Five years later, the hospital was accredited by the Joint Commission on Accreditation of Hospitals (JCAH). This qualified them for federal and local government assistance. Likewise, grants from businesses and foundations were being received with greater frequency: including a $64,000 grant from the Ford Foundation. And in subsequent years, units for surgery, neo-natal care, and outpatient clinics were completed (Yardley and Rogers, 1984).

The male intrusion into the upper echelons of the organization continued to increase. Half of those elected president of the corporation were men as were all the top Administrators. Board members were recruited from the local bourgeoisie though their selection was limited by charter in
that the majority of the members of the Board had to be of Hawaiian (meaning Native Hawaiian) ancestry (Yardley and Rogers, 1984).

One philanthropic donation of note was that of Lani Booth. She left the hospital $600,000. The reason for her generosity is outlined by Yardley and Rogers (1984):

A single incident gave Kapiolani Hospital the money over Queen's Hospital. Lani Booth's sister, Kulamanu, was at Queen's Hospital for some time due to physical and mental illness. Mrs. Booth was suddenly told that the hospital needed the room. She called a cab and brought her sister to Kapiolani Hospital where she was admitted immediately. She remained for several years and enjoyed the best of care. (p.35-36).

Booth also donated $400,000 to Kauikeolani Children's Hospital. This was particularly important because in the upcoming years, Kapiolani and Kauikeolani Hospitals would be developing a more intimate corporate relationship.

By 1970, the hospital possessed a total capacity of 138 beds. The hospital was populated by nurseries, operating rooms, as well as childbirthing facilities. A slight alteration in the corporate charter was made: it deleted the requirement that the majority of the Board be of Hawaiian ancestry. This meant, in essence, that the institution had shed it's last vestige of Kingdom Hawaii and the ethnic outlines of the Hooulu Lahui.

Intermittantly in the last few decades, Kapiolani Maternity and Gynecological Hospital had been discussing the possibility of mergers with other local hospitals. The 1970s would find a quasi-merger relationship between the hospital and the Kuiikeolani Children's Hospital occurring.

Kauikeolani Children's Hospital had been founded in 1909 by Albert Spencer Wilcox in honor of his wife, Emma Kuiikeolani Napoleon Mahelona. Wilcox's parents were among the the Eighth company of American Missionaries stationed in Hilo. Wilcox moved to Kauai where he participated in business ventures and local government. He also founded the Samuel Mahelona Hospital in Kapaa in 1917 in memory of his stepson. (Day, 1984)

In 1972, formal announcement by the two facilities was made regarding the sharing of resources since both were operating seemingly on financial tightropes.

Kapiolani Maternity and Gynecological Hospital and Children's Hospital today announced plans for "marriage" to take place in about three years. ... A joint announcement issued by John H. Magoon Jr., president of Kapiolani's board of trustees, and C.F. Damon Jr., president of Children's board, states that the two institutions will live in the same location - on the Kapiolani grounds - and share common services and facilities as a

---

22 Yardley and Rogers (1984) note that the facility had already changed its name, via charter amendment, from Kapiolani Maternity and Gynecological Hospital to Kapiolani Hospital: this having taken place in 1971.
As a first step in this process, Richard Davi was appointed as Executive Director to both facilities. While legally they remained separate corporations, they shared many management and support facilities (Yardley and Rogers, 1984). Collectively, they become referred to as Kapiolani/Children's Medical Center.

For the following decade, the two hospitals would continue to expand and amalgamate. An on-site building was completed to house certain departments of the State's Medical School as well as physicians offices. Federal and State funds were secured for the continual technological upgrading of the facilities. Relational intimacy was augmented by physical proximity as Children's moved from it's original site to the Kapiolani Hospital grounds. (Yardley and Rogers, 1984).

Reinstitutionalization: Medical Center, 1984 - present

In 1984, the cohabitation of the hospitals finally gave way to formal marriage. The two facilities merged legally into a single corporate entity. The new entity became known as the Kapiolani Women's and Children's Medical Center.

Just prior to the merger, Kapiolani Hospital reported a total of 138 beds. Of these, sixty-eight were classified as medical/surgical, ten as perinatal critical care, and the
remaining sixty as obstetric beds. Children's Hospital (i.e., Kauikeolani) touted eighty-eight total beds: 64 pediatric beds, 12 critical care beds (6 pediatric ICU and 6 intermediate care), and the only 12 neonatal ICU beds in the State of Hawaii (State of Hawaii, 1984).

As of 1985, the Kapiolani Women's and Children's Medical Center could boast a domination of obstetric and pediatric care: a reproduced legacy of its dual parentage. It possessed 52% of all obstetric beds, 74% of all pediatric beds, 100% of all neonatal ICU beds, 16% of all critical care beds, and 6% of all medical/surgical beds in Honolulu (see State of Hawaii, 1985). In addition, the facility sports a physician's office building as well as a close relationship with the University of Hawaii's John A. Burns School of Medicine.

Royal Philanthropy and the Kapiolani Maternity Home

Over the century of the Kapiolani Maternity Home's existence certain themes come to the forefront.

The first is that the Home was nested within a specific project, the Hooulu Lahui, whose original purpose was to combat the apparent depopulation of Native Hawaiians. This maternity home represented one very important prong of that effort. Over time, we find that the eleemosynary character of the institution changed: approaching fee universality.

The fact that the royal philanthropic effort was ephemeral
and small meant that it would have little sustained impact upon the trajectory of the ensemble. The ethnicity of clientel gradually took a backstage to their ability to pay for the facility's services. Eventually, the ties to the Native Hawaiian ethnicity were expunged from the Board of Trustees as well.

Second, and concomitantly, there was movement toward a market orientation. Such an orientation was tempered by the structure of the health sector in general, and the hospital sector of Honolulu in particular. The focus upon maternal care in a market discourse provided for the brisk expansion of the facility into technological medicine. It was a move that fostered community involvement, corporate networking into the local bourgeoisie, and a close relationship with government agencies.

Third, we find that the hospital's project involved the intrusion of the male dominated ethos existing within society to infiltrate what was, in it's early history, a female run and dominated enterprise. This trend accompanied the institution's change from the periphery to the core of the health sector.

And finally, there was a continual expansion of the institution's proposed sphere of dominance displayed over the course of time. That is, there was the transition from a childbirth setting to the that of the foremost institution
of medical expertise in the care of women and children in Hawaii. The transformation was indeed tremendous.
Thus the "half natives" are still humans, through the power and weakness of the oppressor which is transformed within them into a stubborn refusal of the animal condition. We realize what follows; they're lazy: of course - it's a form of sabotage. They're sly and thieving; just imagine! (Sartre, 1966: 15).

The focal object of this chapter is the trajectory of the Liliuokalani Trust and it's offspring: the Liliuokalani Children's Center. The realization of the latter from the bowels of the former took almost seventy years. The bulk of the chapter, then, will be devoted to the activities of the Trust with the Children's Center representing a vortex or culmination of interwoven interests. Despite having no particular place as a "headquarters", the Trust did a significant amount of work under the auspices of the trust instrument.

While the focus of the Liliuokalani Trust was not medical care, it's project to cater to the care of orphan children would later incorporate an interest in mental health inclusive of ethnic psychiatry. While technically given universalistic freedom, the actual activities of the ensemble have focussed on the preferred (sub)population: Native Hawaiians.
In 1909, Liliuokalani wrote her last will and testament. Among the provisions contained within it were the disposition of both principle and income of the trust estate "for the benefit of orphan children in the Hawaiian Islands, the preference to be given to Hawaiian children of pure or part aboriginal blood" (Liliuokalani Trust, 1962: 31). Two years later, she would expand the template to include "orphan children and other destitute children" (p.31). This addition to the template extended the purview of the trust instrument tremendously: including not only the familially disenfranchised, but expanded toward a recognition of class and ethnic categories.

Liliuokalani endowed the trustees, to be three in number, with tremendous latitude in directing the specific activities of the trust. Included within the realm of discretionary activities were: (1) the manner, number, and selection of children to be served; (2) the number of institutions created; (3) the activities constituting proper care of the selected children; and (4) the range of plans for the care of wards on a case by case basis.

With such powers vested in the trustees, their selection and succession were of particular import and was specifically explicated. After the appointment of the original three trustees by Liliuokalani herself, all subsequent vacancies were to be "appointed by the judge of a
court of competent jurisdiction but only upon the written nomination of the remaining trustee or trustees" (Liliuokalani Trust, 1962: 32). The continuity of the trust administration, then, could be maintained.

Like the other royal philanthropic projects, the Liliuokalani trust specified a unique population of interest and concern: i.e., destitute children.

**Series: Class and Orphanism, pre-1909**

The transference of cultural status to wealth status was a result of the privatization of real property within a money economy. The passage of the Mahele of 1848 was one major step in this process. With the creation of the plantation economy based on the production of sugar, the kingdom became drawn into the thick of the capitalist world economy.¹ The inheritance of real property became the cornerstone of aristocratic/bourgeoisie intergenerational elitism. Liliuokalani was a beneficiary of this transfer of wealth and privileged cultural status. But, she also held a position of esteem as a sovereign of high native and western cultivation.

¹ See Wallerstein (1974, 1980, 1989) for general discussions of the expansiveness of the capitalist world system.
Liliuokalani

Liliuokalani was the last monarch to rule the Kingdom of Hawaii. She was a designated successor to the throne: succeeding her brother David Kalakaua to that position. When Kalakaua died in January of 1891, Liliuokalani acceded to the position of sovereign. She was the second, and last, of the Kalakaua dynasty.

Liliuokalani was born in 1839, the daughter of Kapaakea and Keohokalole. As a child, she was adopted by Konia and Paki: making her the hanai sister of Bernice Pauahi. Like the previous three sovereigns, Liliuokalani had attended the Royal School as a youngster. By virtue of her genealogy, she was a member of the Privy Council: an executive cabinet advisor to the sovereign.

In 1862, she married John Owen Dominis. Shortly thereafter, Dominis became active politically: being governor of Oahu, a member of the Privy Council, and Commissioner of Crown Lands. He died within a year of

---

2 Her brother, William Pitt Kalahoolewa Leleiohoku, was initially named heir by Kalakaua. But he died of pneumonia in April of 1877. Thus, Liliuokalani became the heir apparent. (Day, 1984).

3 Bernice Pauahi would marry Charles Reed Bishop. She was related to the Kamehameha line through her mother, Konia - a granddaughter of Kamehameha I, and her father, Abner Paki - descended from Kekaulike. Paki was a Supreme Court Justice, a governor, and member of the House of Nobles and Privy Council. Pauahi would inherit land from her parents, but more substantially from Princess Ruth Keelikolani: hanai mother of Liliuokalani's brother Leleiohoku. The bulk of what is now the Bishop Estate was composed of lands Pauahi inherited from Princess Ruth.
Liliuokalani's ascension to the throne. They had no children; and she did not marry again.

Prior to her ascension, she was highly involved in Kingdom government at the executive level. For a brief period Liliuokalani had acted as regent of the kingdom in her brother's absence. She also was present at Queen Victoria of Great Britain's 50th Jubilee: accompanying Queen Kapiolani, her sister-in-law.

Under Kalakaua, the power of the throne had been steadily eroding. Kalakaua had inherited from his predecessors very strong economics ties to the United States which got even stronger during his reign, even though the royal families felt stronger social and personal affinities to the monarchies of Western Europe. The powers of the throne were further weakened by the signing of the "Bayonette Constitution", which placed more authority within the purview of the cabinet.

Liliuokalani's attempts to reestablish former powers of the throne were combatted by the socially and politically powerful annexationists. There had been American annexationist movements as early as the 1830s and in 1843 when Great Britain had seized the kingdom. In the 1890s, those with such an orientation held powerful posts in government and commerce. At the climax of this political

---

4 Kalakaua had embarked on a world tour during his tenure as King. Armstrong (1904) gives a rather negative characterization of the King during this period.
struggle, the so-called Committee of Safety took matters into their own hands: overthrowing the government by capturing Queen Liliuokalani in a bloodless coup. The coup was accomplished with the complicity of the U.S. Consul and American marines (see Blount, 1983). The usurpers promptly formed the Provisional Government, then the Republic of Hawaii. An abortive counter-revolution occurred in 1895. But with annexation by the U.S. Government in 1898, the faint hope of regaining the Kingdom was lost.⁵

For some time after the coup, Liliuokalani was imprisoned. But while her political power was quelched, her wealth remained in tact. The overthrow, then, was a political discontinuity and not an economic one.⁶ The wealth structure, which preserved the bourgeoisie status of the royal family estates, remained unscathed.

Class, Ethnicity, and Orphanism

It is clear that the royal families had recognized the nascent class differences that were emerging within the later Kingdom era. Many projects within the Kingdom were designed to aid the "destitute".

---

⁵ The Wilcox election to the Congress under the Home Rule Party was a "last gasp" attempt to regain the Monarchy through established political institutions.

⁶ The U.S. market already represented an overwhelming percentage of Hawaii's exports production.
And, certainly, categories of ethnicity were evolving given the cosmopolitan make-up of the population. The Native Hawaiian represented one such category: referred to at the time as simply "Hawaiians" or, given the same term employed for citizenship, those of "aboriginal blood".  

It is unclear how orphanism was selected as the substantive object of Liliuokalani's philanthropy. But while the target population was unique, the template of the philanthropic project was very much in line with those preceding it.

In any case, class status, ethnicity, and family status were the important categories in the drawing up of the trust instrument.


Deposed Queen Liliuokalani died in 1917. Her passing was of great note to the people of Hawaii. Thrum (1918), reports on the event.

Liliuokalani, she who held Hawaii's scepter last, is no more; the link that connected the present with the monarchial days of the past is broken, and her people, with aliens from other lands, are in sorrow. The ex-queen after some months of gradual failing health, owing to her advanced years, passed away peacefully at her residence, Washington Place, Honolulu, Sunday, Nov.11th, 1917, at 8:30 a.m., surrounded by remaining distant relatives, friends and faithful attendants, aged 79 years, two months

7 The debate as to whether the term "Hawaiian" stood for citizenship or ethnicity has often been one of contention if left unspecified.
and nine days; the last of her family and ending a long line of distinguished high chiefs from which she proudly claimed descent. (p.102).

The Trustees

The original trustees of the estate were Archibald Cleghorn, Curtis Iaukea, and W.O. Smith and had been named by the former Queen herself in 1909. Cleghorn was a brother-in-law of Liliuokalani, having married her sister, Miriam Likelike in 1870. During his lifetime, he served on the Privy Council, the Board of Health, as Governor of Oahu, and as President of the Queen's Hospital, among other posts. He was the father of Princess Kaiulani, the heir apparent to the throne had the kingdom not been overthrown.

Curtis Iaukea had much experience with the royal family. At various times he worked as general collector of customs, chamberlain of the king's household, and member of the royal entourage. He continued government posts and political activity after the overthrow of the kingdom. In 1909, he was named managing trustee of the Liliuokalani Trust while serving as Liliuokalani's private secretary.

W.O. Smith was an attorney who, ironically, had been an integral part of the Committee of Safety which had overthrown Liliuokalani in the coup of 1893 (Kuykendall, 1967). He had apparently been quite prominent as an attorney in the Islands: for he had served as a trustee for the Lunalilo Trust previously (see chapter 4).
Orphanages

In the original deed of trust dated December 2, 1909, Liliuokalani instructed the following:

As soon as practicable with due regard, always, to the retention and investement of sufficient of the corpus or principal of the estate in income producing property or securities to provide for the continued maintenance thereof, the Trustees shall extend such work on the establishment and maintenance of an institution or institutions for such orphans, and provide for the government thereof. ... Every such institution so established shall bear the name of "Liliuokalani". (Liliuokalani Trust, 1962: 31).

The original proposition, then, was to create an institutional means of dealing with the target issue: very much in keeping with the template of the previous royal philanthropic projects. Liliuokalani specified few of the parameters of the project itself, thus giving great latitude for discretion on the part of her trustees.

In such work, whether before or after the establishment of any such institution, the Trustees may exercise their entire discretion how far to care for or assist in caring for or educating or otherwise providing for any child or children, according to the circumstances of such cases, whether such child or children shall reside within or without any such institution (Liliuokalani Trust, 1962: 31).

Unlike the previous royal philanthropic projects, Liliuokalani did not specify in great detail her definition

---

8 Specifically, for orphan and destitute children of Hawaii, with preference for Native Hawaiians.

201
and proposed solution to the social issue selected. The trust instrument itself was a foundation to a solution that would be determined at some later time in consideration of the circumstances defined by designated others (i.e., the trustees). In 1909 the net value of the estate was estimated at about $125,000 (Honolulu Star-Bulletin, 1934).

Between 1917 and 1934, the trustees activities were engaged mainly in the management of estate business. Although the net value of the estate had been growing, it was determined that the trust funds would be insufficient in providing adequate initial and operating funds for an orphanage. In 1931, the trustees purchased land from City Mill Company: 20,561 square feet in Waikiki for $7,196.35. And there were negotiations for the estate to purchase an entire block in Waikiki (Honolulu Advertiser, 1931). In later years it would be Waikiki property which would boost the estate's net value considerably.

By 1933, the net value of the estate was estimated to be $835,330 which was sufficient in producing $25,000 in annual income. The following year, the trustees asked the court for the authority to expend such income on orphaned and destitute children in lieu of establishing an orphanage.

---

9 In this regard, the Liliuokalani Trust is similar to the Bishop Estate of Bernice Pauahi Bishop. The manifest result is that policy control is much to the discretion of trustees in the interpretation of "missions".

10 Trustees at this time were Curtis Iaukea, A.G.M. Robertson, and L.J. Warren.
They stated that they regarded the institutional method as "obsolete, unwise and inefficient in comparison with other sociological methods ... by placement in private foster homes, boarding schools and other suitable situations where they would have individual care under proper case work and supervision" (Honolulu Star-Bulletin, 1934: 1).

The trustees' petition for an indefinite postponement of the orphanage was heard by Judge A.M. Cristy in October of 1934. Given the language of the trust document and the discretion allotted to the trustees therein, the postponement was granted speedily in Equity Court. The creation of an orphanage was postponed indefinitely; and in the due course of time would be discarded altogether.

Varied Care

As early as 1936, the Trust was engaged in various types of assistance to orphans and destitute children. In that year the trust\(^{11}\) reported assisting sixty-one children: fifty-nine which remained in care for the following year. Fifty of the children were between the ages of 6 and 15; their ethnic breakdown was listed as: 36 Hawaiian-Caucasion, 11 Hawaiian-Chinese, 9 Hawaiian, 3 Hawaiian-Filipino, and 2 Hawaiian-Samoan. Fifty-two were living in private homes, six at Kamehameha Schools, and

\(^{11}\) Victor S.K. Houston had replaced L.J. Warren by this time. Later in 1937, Houston would resign and be replaced by Cooke Trust Company, appointed by Judge D.E. Metzger.
three were residing in institutions. (Honolulu Star-Bulletin, 1937a). At that time, 1937, the trust was one of the largest in the territory with an annual income approaching $60,000 (Honolulu Star-Bulletin, 1937b). In subsequent years, the estate's value would continue to rise (Honolulu Advertiser, 1940a; Honolulu Advertiser, 1960; Kamakahi, 1989).

The trust was continuing to place charges in several child welfare and boarding homes. In 1948, the trust had a staff of seven members and was overseeing the care of one hundred and twenty-five children. 12 By that time, it was expanding its services and moving to its own office (Honolulu Star-Bulletin, 1948).

By 1960, the value of the Trust lands on Oahu, Maui, and Hawaii were estimated to be worth $6 million. This had generated an income, in 1959, of $258,572.43 of which 96% was spent on children under the Trust's care. Four hundred and twenty active cases were reported by the Trust's Child Welfare Department. Interestingly, the Trust was employing the services of psychiatrists and psychologists in "advisory capacities". (Honolulu Advertiser, 1960). In this sense, the Trust could be said to be entering the very fringes of the health sector via the incorporation of medical practitioners within their spectrum of services.

---

12 Trustees were Houston, Clorinda Low Lucas, with Cooke Trust Company as managing trustee.
Though the focus was the general care of children, the Trust would be interested in the general mental as well as social well-being of those under its care. This led them to be interested in the mental health and social status of Native Hawaiians per se.


In 1962, the Trust embarked upon a socio-economic survey of Native Hawaiians through its newly appointed Advisory Board. The Advisory Board consisted of eighteen members from the community. The members composed various committees: being contributors to the Survey Committee and/or one of three subcommittees. Each of the three subcommittees focused upon a particular substantive area: crime and delinquency, education, and health.

Trustee Gordon S. May, in the forward to the study, explains that though originally intended as an internal document, the results were such that other agencies might employ the information for cooperative (present and future)

---


14 The two other trustees were Clorinda Lucas and the Cooke Trust Company.
community planning. He states, quite succinctly, that the analysis "of the available data studied has led the committee to the general conclusion that a segment of the Hawaiian people are beset by serious economic and social problems" (Liliuokalani Trust, 1962: i).

Shortly after the document's public release, the study was profiled in the media. Reported was the fact that although 100,000 Hawaiians and part-Hawaiians comprised 17% of Hawaii's population, they accounted for approximately 40% of all destitute families aided by the community, 42% of illegitimate births, 20% of all divorces, and only 5% of all high school graduates (Liliuokalani Trust, 1962). The newspaper recorded that the "Trust hopes to lead in two areas: (1) to reduce the incidence of social pathology and (2) to stimulate youth to higher aspirations of achievement" (Honolulu Star-Bulletin, 1963).

In virtually every aspect of interest to the investigation it was found that Native Hawaiians fared very poorly viz-a-viz other ethnic groups residing in the State. This poor socio-economic showing was especially pronounced for "pure" Hawaiians.

In terms of physical health, Native Hawaiians were found to have the highest infant mortality rates, highest mortality due to heart disease, the worst dental health among children, and the lowest use the health services in
general. Cultural beliefs and lack of health education were cited as contributing factors.\textsuperscript{15}

With regard to mental health, it was reported that Native Hawaiians were "less represented in the mental hospitals than in other problem areas" (Liliuokalani Trust, 1962: 11). Native Hawaiians constituted approximately 15\% of the hospitalized mental patients in the State where such cases were said to represent (along with Caucasians) a disproportionately large number of "personality disorders" and a disproportionately small number of "psychotics": the converse of patterns exhibited by Japanese and Filipino groups.

The suggestions of the report, in assimilating information from various other community groups, was the broad-based recognition of the problem of ethnic stratification in Hawaii. Concomitantly, there was a recognition of the lack of assimilation of Native Hawaiians into the island community and social structure.

Community organizations contacted are deeply concerned about the "Modern Hawaiian" feeling that they more than any other group are in need of programs of education and counselling in: money management, family living, [the] nature of health and disease, parent-child relationships, sex and

\textsuperscript{15} See Wegner (1989) for a recent compendium of articles dealing with the health of Native Hawaiians. Ikeda's (1988) report on education is also relevant here as is Barringer and O'Hagan's (1989) monograph on Native Hawaiians.
its present social consequences, and the advantages of a formal education. (Liliuokalani Trust, 1962: 18).

The focus of the 1962 Advisory Board study was to locate Native Hawaiians within the Hawaii society of the time. They did so using the template of the western weltanschauung in reference to the notion that Native Hawaiians must assimilate into it. This notion would be modified in subsequent years.

Institutionalization: Children's Center, 1966 - 1972

During the early nineteen-sixties, as Hawaii was enjoying its newfound statehood status, the Liliuokalani Trust was still providing a broad-based approach to assist Native Hawaiian children. At this time, they were serving approximately three hundred children annually. Essentially, the Trust's Child Welfare Department had continued the mandate decided upon by the trustees of 1934.

The Advisory Board report of 1962 had served to coalesce the information regarding the Native Hawaiians as a whole, its effect upon children within that ethnic group, and it had suggested possible focal issues. It's underlying premise had been the assimilation of Native Hawaiians into Westernized society.

In 1966, the Trust created the Liliuokalani Children's Center as an outgrowth to what it had called previously its Child Welfare Department. The $306,000 facility housed a
staff of fourteen social workers which strived "to give the children a 'whole personality' through ministry, social work, medicine and education" (Honolulu Star-Bulletin, 1966). As such, the ensemble acted as a moral entrepreneur.\textsuperscript{16}

The template for the organization was that set forth by the Advisory Board report of four years earlier in "efforts which promote the educational, health and social welfare of the Hawaiian children and their people" (Liliuokalani Trust, 1962: 30). By this time, no mention was made concerning the now forgotten notion of creating an orphanage. Instead, the institutionalization of the trust services would be represented in an amalgam of interventionist strategies: though in a more formalized manner than in the past.

In the meantime, the Trust was becoming interested in developing some of its vast holding of real properties. Of particular interest were attempts to develop it's lands on the Big Island's Kona coast, which was undergoing a development "boom". Work had already begun on a 130 acre residential subdivision and an apartment building as well as attempts to change the land zoning of some properties from agricultural and conservation use to urban use were in process (Honolulu Star-Bulletin, 1969).

\textsuperscript{16} See Becker's (1963) discussion of moral entrepreneurs as definers of proper social action.
Nana I Ke Kumu

One of the more significant changes in the orientation of the Children's Center was the creation and the publication of the first of two volumes entitled Nana I Ke Kumu: Look To The Source (1972). The volume incorporated the knowledge of Hawaiiana scholar Mary Kawena Pukui\(^{17}\) in an attempt to define a culturally informed, ethnic psychiatry.

The volume attempted to complement the Advisory Board's 1962 report by adopting an explicitly Native Hawaiian orientation toward mental health. They employed Pukui's knowledge of the Native Hawaiian weltanschauung to locate cultural foundations for orientations, discourse, and possible areas of intervention. The publication served not only to codify Native Hawaiian categories of mental health and meaning, but to sensitize intervention strategies for practitioners.

The Children's Center was not just willing to reproduce western categories in treatment programs any longer. Neither was it willing to just report statistics using western psychiatric categories in terms of ethnicity. The volume, which would be supplemented by a second volume in 1979, attempted to allow practitioners to understand their

\(^{17}\) Pukui was a bridge between traditional Native Hawaiian culture and Western-styled scholarship. Her many works included subjects such as chants, translations, Hawaiian language dictionaries, and so on.
clients' cultural definitions of their actions and circumstances. Unlike the 1962 report, there was no inherent "pathology" posited within the Native Hawaiian population, but rather there existed a working assumption of disparate, but conterminous, cultural interpretations: that is, the western cultural hegemony was no longer accepted.

The so-called "Hawaiian Renaissance" was taking hold in Hawaii at the time. The social movement revolved around a renewed interest by Native Hawaiians in their cultural history and practices. Native Hawaii music, arts, language, and the general weltanschauung was investigated anew. Pukui represented a bridge between traditional cultural knowledge and contemporary scholarship. Her participation in the Children's Center's publications represented one prong of a generalized diffusion of Hawaiianana in the islands at the time.

**Reorganization: Expansion of Services, 1973 - present**

The universalistic leeway which Liliuokalani had allotted to the Trust had not deterred them from focussing almost exclusively upon Native Hawaiians and Native Hawaiian children. Although the deed of trust specified a "preference" for those of aboriginal blood, the Trust had always treated it as a mandate for action, and this mandate was adopted by the Children's Center.
The enveloping Trust, in particular its finances, determined the extent to which the Center could disperse services. The Trust's corpus was quickly rising as land values in general began escalating in Hawaii. The Trust possessed land holdings of some 19,000 acres within the State. The bulk of their assets in 1978 centered round sixteen acres that it owned in Waikiki. At that time, the estate was valued at over $40 million. Surprisingly, this financial boon placed the Trust in an uncomfortable position:

The Liliuokalani Trust must pay out 85 percent of adjusted net revenues or two-thirds of 5 percent (3.33 percent) of the appraised value of trust assets yearly, whichever is greater, to continue to be classified as a private operating foundation. (Honolulu Advertiser, 1978).

As an eleemosynary project, the Trust had to disperse a certain percentage of assets. Even though the Children's Center's operating budget in 1977 was about $1 million dollars, the Trust was in danger of not being able to distribute enough of its wealth with its present arrangement of services. The Center's multiple-service orientation was organized in three sections: individual and family services, group services, and community development. (Honolulu Advertiser, 1978)

To combat their abundance of wealth, the Trust/Center decided to expand its services by operating "branch" facilities throughout the State. These children's
welfare/support centers were established in Kapalama, Leeward and Windward Oahu, in Hilo and Kona, as well as on Molokai; with plans expected to do likewise on Maui and Kauai.

In the meantime, the trust corpus was continuing to grow as it became more involved in the development of its properties. Such developments included the building of condominiums and hotels in Waikiki and construction of lands on Hawaii's Kona coast (Honolulu Advertiser, 1982). In 1986 the fair market value of the Trust's holdings were estimated at $90.5 million, with its services reached 3600 children (Liliuokalani Trust, 1986). The continual expansion of services was partially determined by the law regarding eleemosynary trusts: that is, a certain percentage of the estate's value had to be distributed to beneficiaries.

The reorganization of the Trust/Children's Center was the result of the marked increase in its assets and holdings. Still, the notion of the orphanage was spurned in lieu of the multifaceted approach that reflected the history of the Trust's service orientation.

**Royal Philanthropy and Trust/Children's Center**

The Liliuokalani Trust was the last of the philanthropic projects of Hawaii's royal families. Like the other projects, the state of the original wealth can be traced to the ownership of real property in conjunction with
the transference of cultural/political status into wealth status.

The political discontinuities which resulted from the overthrow of the kingdom had no substantial effect upon the socio-economic standing of deposed Queen Liliuokalani. She was able to create the trust instrument in the Territory of Hawaii using her real properties as the trust corpus.

Three aspects of the deed of trust are of particular relevance in discussing the subsequent trajectory of the Liliuokalani Trust/Children's Center.

First, the documents of 1909 and 1911 indicate that there were three salient categories of interest to the former Queen. These three categories were familial situation, ethnicity, and class standing. Indeed, neither of these categories was entirely novel with regard to the royal philanthropic projects in Hawaii. The focus upon children, particularly orphans, however was unique. Over time, the focus upon children would also involve the assessment of the Native Hawaiian community and weltanschauung.

A second theme of the original template was that of qualified universality. Native Hawaiians, i.e., those of pure or part aboriginal blood, were a preferred beneficiary group; but, the services were not confined to them. The history of actual practice, however, demonstrates that Native Hawaiians have been the exclusive interest of the
Trust/Center. The fact that the ensemble is a closed system and remains on the periphery of social/health services has led to few challenges to its mode of operation. Ironically, it is the most active of the Crown-Based Health Ensembles in the Native Hawaiian community at large.

The third theme of the trust instrument was the amount of discretion that it allowed its executors. The original idea of creating orphanages was optional and the proper course of action was left in the hands of the trustees: who were to act as they saw fit given their assessment of circumstances. In fact, the orphanage notion was discarded in the 1930s, in favor of a multifaceted approach, never to be resurrected. This broad-based service orientation has continued and expanded into such areas as an ethnic psychiatry and "branch" operations which are spatially dispersed.
People speak to us of "social facts,"¹ but if we look at this more closely we shall find the same vicious circle. ... It is the syncretic totality which we must now attempt to describe. (Sartre, 1948: 16-17).

Each of the previous four chapters has discussed the socio-historical development of a particular health ensemble. That is, each chapter presented a brief case study of "historical individuals". In this chapter, the Crown-Based Health Ensembles (CBHE) panel, rather than the ensembles themselves, is of primary interest.

The previous discussions of the CBHEs have been contoured by certain panel characteristics. Here an attempt is made to comparatively evaluate the coupling of structural characteristics with ensemble trajectories.

**Conceptualizing the Panel**

In chapter one, the case was made that the four ensembles represented a panel by virtue of their sharing of certain abstract characteristics. In review, these characteristics included: (1) each ensemble's creation was

¹ The term "social facts" was employed by Emile Durkheim to refer to social processes that existed independent of the characteristics of constituent components: i.e., latent structural processes.
intimately tied to the Crown; (2) each ensemble was created at least in part through philanthropy; (3) each ensemble targeted a health concern; (4) each ensemble adopted a western approach to the definition and treatment of the issue of concern; (5) each ensemble originally focused upon the Native Hawaiian population; and (6) each ensemble was originally "buffered" from a market orientation by mediating structures.

Chapters three through six discussed each ensemble in light of its own particular development. These case studies revealed that each ensemble participated within a unique set of circumstances while also being immersed within overlapping political-economic and socio-cultural contexts. It is the larger parameters of health care policy and practice which will now be of interest.

The question of focus is no longer how a particular ensemble's development can be described, but rather what are the nonrecursive political-economic processes that influenced these ensembles to develop as they did? The analysis which has been idiographic and diachronic will now inform us of the nomothetic and synchronic dimensions of the Crown-Based Health Ensembles.

**Structural Characteristics**

Certain empirical characteristics of the CBHEs that were scrutinized during the descriptive discussions.
Historically, the year of establishment, the form of incorporation, and the target population were noted. The date of establishment immediately placed ensembles within a concrete societal milieu and located them vis-a-vis other ensembles. While philanthropy was an integral part of the creation of each CBHE, the particular form of organization and the specificity of their respective templates varied.

The contexts of Hawaiian history were obviously not uniform for the CBHEs. Each occupied a different location within the political-economic and social organization of Hawaiian society. As a consequence, the changes that affected Queen's Hospital as the center of western medical care in the islands might have had negligible impact on Lunalilo Home. There were many changes in the health sector and the interpretation of mission templates that can be seen as penetrating into only specific health sub-sectors.

Society in Hawaii changed drastically in the time between and including the kingdom era and statehood. Simplifying the complex melange of factors that help differentiate and coalesce the CBHEs is the task of this section. Nine characteristics are listed in table 1 for each ensemble: (1) the year of the ensemble's establishment (founding); (2) the template under which the ensemble was founded (policy); (3) the ensemble's primary funding source (funding); (4) the targeted population (target pop); (5) the identity of any nesting agency (nested); (6) the degree of
the ensemble's political-economic involvement (P-E ties); (7) the health subsector occupied by the ensemble (sector); (8) the extent to which the ensemble received media attention (media); and (9) the degree of technology employed by the ensemble in providing services (technology).

Table 1 comparatively demarcates the four CBHEs in relation to certain characteristics of interest. Table 1 is a selective summary of certain aspects of the four CBHEs. In this comparative display, both stability and transformation can be noted. With regard to some characteristics, the ensembles have remained the same; and with other characteristics they have changed. However, the factors of change and consistency are not the same for all ensembles.

Kapiolani Hospital, for instance, has changed over time with respect to all seven characteristics in which original versus present values are listed. Queen's Hospital has changed with respect to three factors: i.e., primary funding source, target population, and the ensemble's nesting canopy. The Lunalilo Home has altered its operation with regard to primary funding source and media attention. And, finally, the Liliuokalani Trust has altered it's position in the health sector from a custodial to a social service organization. The extent of change (and stability) between and within the ensembles has not been uniform.
Table 1
CBHEs With Regard to Focal Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Queen's Hospital</th>
<th>Lunalilo Home</th>
<th>Kapiolani Home</th>
<th>Liliuokalani Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>founding</td>
<td>1859</td>
<td>1878</td>
<td>1890</td>
<td>1909</td>
</tr>
<tr>
<td>policy</td>
<td>private</td>
<td>trust</td>
<td>private</td>
<td>trust</td>
</tr>
<tr>
<td>funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>gov't</td>
<td>trust</td>
<td>social</td>
<td>trust</td>
</tr>
<tr>
<td>present</td>
<td>clients</td>
<td>tr/cl</td>
<td>clients</td>
<td>trust</td>
</tr>
<tr>
<td>base</td>
<td>$/RE/tr</td>
<td>S/$</td>
<td>$</td>
<td>RE</td>
</tr>
<tr>
<td>target pop</td>
<td>NH</td>
<td>NH</td>
<td>NH</td>
<td>NH</td>
</tr>
<tr>
<td>preference</td>
<td>All</td>
<td>NH</td>
<td>All</td>
<td>NH</td>
</tr>
<tr>
<td>nested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>gov't</td>
<td>trust</td>
<td>social</td>
<td>trust</td>
</tr>
<tr>
<td>present</td>
<td>none</td>
<td>trust</td>
<td>none</td>
<td>trust</td>
</tr>
<tr>
<td>P-E ties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>high</td>
<td>low</td>
<td>low</td>
<td>low</td>
</tr>
<tr>
<td>present</td>
<td>high</td>
<td>low</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>hospital</td>
<td>custodial</td>
<td>maternal</td>
<td>custodial</td>
</tr>
<tr>
<td>present</td>
<td>hospital</td>
<td>custodial</td>
<td>hospital</td>
<td>soc.serv.</td>
</tr>
<tr>
<td>media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>high</td>
<td>high</td>
<td>low</td>
<td>low</td>
</tr>
<tr>
<td>present</td>
<td>high</td>
<td>low</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>technology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>original</td>
<td>high</td>
<td>low</td>
<td>low</td>
<td>low</td>
</tr>
<tr>
<td>present</td>
<td>high</td>
<td>low</td>
<td>high</td>
<td>low</td>
</tr>
</tbody>
</table>

$=\text{cash}; \text{RE}=\text{real estate}; \text{tr}=\text{trust}; \text{NH}=\text{Native Hawaiian}; \text{soc.serv.}=\text{social service}.
In treating the CBHEs as a panel, the question that needs to be addressed is: Are there patterns that can be discerned from this set of ensembles with regard to the characteristics of interest? The following sections will posit that the CBHEs, as mediations of general processes in health policy and practice, do inform us of latent patterns.

**Latent Factors**

The comparative data in table 1 displays information on the CBHEs with regard to nine empirical characteristics: i.e., information that could be gleaned from a positive investigation. In essence, these characteristics represent empirical indicators rather than theoretical constructs. In this section, it is proposed that these empirical traces are indicative of three underlying, latent constructs: social buffers, universality, and sector position. It will be posited that the panel reflects and demonstrates the efficacy of these latent factors in accounting for the trajectories of each of the CBHEs and the group as a whole.

**Social Buffers**

In common parlance, a buffer refers to something that interposes between two agents to moderate adverse influences. The buffer, then, can be seen as a prophylactic which preserves the fidelity of at least one agent: or,
conversely as a hinderance to social influence. This concept can be easily transferred into the social sphere, where buffers refer to social milieu or environments.

Within systems of hierarchical social organization, it can be argued that some systems are nested within other systems (see Parsons, 1951; Denzin, 1989). Or, it can be said that certain nodal points act as gatekeepers or "linking pins" between other nodes. However this triadic relationship is couched, the fundamental idea expressed is that the effects of social agency are often mediated by intervening agents. These mediators of social influence will be referred to as social buffers because they filter the effects of agency.

With respect to the CBHEs, we can posit that social buffers refer to the "nesting" of ensembles within environments. Environments can refer to the political-economic system, the tenor of cultural and/or social groups, the constructed organizational template for action, etc. The milieu need not be conceived of as exclusively external, but instead as permeating and contextualizing. An ensemble, for example, may take a course of action by virtue of the fact that it assesses its possibilities with regard to organizational resources, discursive parameters, prospective actions by relevant external agencies, and so on - we may speak of "internal environments".
Four characteristics in Table 1 may be said to be indicators of social buffers for ensembles: ensemble template, primary funding source, degree of nesting, and political-economic ties. These characteristics allow us to gauge the extent to which the ensemble is buffered from certain environmental influences.

The policy and funding variables inform us as to the extent to which these health organizations are nested within a specific trust instrument. If the health ensemble itself is a beneficiary of the trust res, this translates into a great influence by the nesting trust instructions and the estate (i.e., see funding variable). The trust, then, acts as a buffer to external influences which can often only be modified through the legal system. It must be remembered that the trust template exerts a social influence upon the continual operation of the estate as well.

The nested variable also provides information regarding external influences upon ensembles. A nested trust ensemble exists only to the extent that the trust exists; the trust's influence is univocal and ubiquitous. While ensembles are in a sense always nested, the extent of direct influence is often diffuse. Queen's Hospital originally was a child of the kingdom government, but later this direct, encompassing influence was severed. Kapiolani Hospital was originally nested within the Hoola Hooulu Lahui, but gradually this
influence dissipated. It could be said that both Hospitals are now "unnested".

The political-economic ties variable indicates the extent to which such influence flows into ensembles. In essence, this flow of external influence into ensembles reflects the absence of social buffers - that is, such effects are not mediated by nesting agents.

The four CBHEs do display patterns with regard to social buffers. The Lunalilo Home and the Liliuokalani Trust demonstrate the encompassing effects of the trust instrument as a social buffer. The trust has acted as an inhibitor to change. On the contrary, both Queen's Hospital and Kapiolani Hospital have shown movement away from buffers toward an "unnested" existence. In short, they have entered into the health care marketplace. As unbuffered ensembles, they are entrenched within a location of rapid social change and political-economic influence.

Universality

Universality is another dimension of the CBHEs that can be gleaned from the empirical aspects of table 1. The concept refers to the inclusion of all members of a population with regard to some resource or object. In reference to the CBHEs, universality refers to the extent to which ensemble services are available to everyone without "arbitrary" limitations. As mentioned in chapter three,
what is considered an arbitrary limitation is a value judgement expressed within a given orientation. For example, the application of income criteria (or any other criteria for that matter) may in one context not be viewed as arbitrary while being viewed as capricious within another context.

The two variables in table 1 which are indicative of the universality construct are the target population and the level of media attention.

Originally, all the CBHEs targeted the Native Hawaiian population. Lunalilo Home and Kapiolani Hospital were exclusively intended for Native Hawaiians; Queen's Hospital and the Liliuokalani Trust were established to cater primarily to the Native Hawaiian population. At present, Queen's Hospital and Kapiolani Hospital have entirely removed this "arbitrary" ethnic barrier to entry. On the contrary, the Lunalilo Home and Liliuokalani Trust have maintained, in accordance with the trust directives, a Native Hawaiian focus.

Media attention, if nothing else, reflects interest in the ensemble with regard to what may be considered to be of interest to the general populous. When the CBHEs were established, the elan of the Hawaiian kingdom and Native Hawaiians was still strong. Queen's Hospital was the vortex of tremendous interest by almost all facets of the population by virtue of it being the first hospital for the
general public within the kingdom; it has retained high media visibility, partly self-generated as advertisements, and as the largest health system in the islands. Kapiolani Hospital which existed as a novelty for the first three decades of operation attained increased media attention as it transformed itself into a community hospital; it continues to attract and perpetuate media attention. The Lunalilo Home was created within the context of much pomp and circumstance, however it has virtually disappeared from the scope of modern mass media. The Liliuokalani Trust has been a low profile entity throughout its existence except for occasional bursts of interest usually associated with the value of the trust estate.

Originally there seems to have been great media interest in the ensembles by a temporal dimension. The earlier facilities were novelties as they virtually defined new means of conceptualizing and addressing health/social issues. However, the latter institutions were seen as following the guidelines of an already defined template; and therefore were less socially significant viz-a-viz their milieu. More recently, high media attention has been partly self-motivated: that is, media attention is partially a function of advertisements and attention produced by the ensembles themselves. There is also a direct, positive relationship between the level of universality of the target population or its implications for the general social issues
and the level of media attention: i.e., the more "universal" the target population, the higher the media attention. Conversely, the more restricted the services are with regard to the target population, the lower the general media attention. Spurts of media attention for non-universalistic ensembles has usually taken the form of "threats to universality" (e.g., Lunalilo Home's receipt of Territorial funds and the Liliuokalani Trust's Advisory council reports).

**Sector Position**

In the previous chapters of this dissertation, the notion of the health sector has been mentioned. The health sector is a concept that usually refers to the collectivity of health ensembles within a given context. The health sector is aptly conceived of as a heterogeneous array of ensembles providing any of a number of levels of care. For instance, we can speak of a hospital sector (which itself may be divided into health systems, medical centers, community hospitals, HMOs, and so forth), a custodial care sector (e.g., nursing homes, mental hospitals, care homes), a social service sector (e.g., nursing homes on wheels, home intervention services, counselling services), and other sectors depending upon our own orientations (e.g., tertiary, secondary, and primary sectors, respectively). Each "sub"-sector is situated within a different place within the
general health sector. These categories of nested sectors are historical and contextual. Associated with sector location is technological sophistication. Technology not only refers to the level of services performed, but also to the "quality" of the personnel with regard to technical knowledge, the sophistication of machinery/hardware, and the incorporation of technological change.

Two variables in table 1 are indicators of the sector position of ensembles: sector membership and level of technology employed. Sector membership refers to the legitimation of ensemble practices by external (especially political) agencies. The fidelity and gradations of the categories are contextual: for instance, what passed as a hospital in 1860 would scarcely pass for one in 1960. While an ensemble may remain in the same sector over time, it is not preordained for it to do so. Kapiolani Hospital, for instance, changed from being a maternity home, a short term custodial facility, into a hospital. This required appropriate internal, external, and relational transformations be made concomitantly. Organizational changes were also required, especially with regard to the Territorial Supreme Court, to recapitulate the Liliuokalani Trust's mission from establishing an orphanage (a custodial sector function) into a social service organization. Changes in the political-economic and/or social-cultural milieu may also be required in order for an ensemble to
remain classified within the same sector. For instance, the passage of the Hill-Burton Act created an entirely new set of standards by which organizations had to adhere in order to be classified as hospitals. An ensemble's position, then, is something that must continually be maintained and/or produced.

Latent Factors

The three latent factors discussed (social buffers, universality, and sector position) represent parameters which can be used to locate the positions of ensembles viz-a-viz their various milieu. Some generalizations can be made regarding each of these factors.

Social buffers are mediative nesting structures. The ubiquity of social buffers acts as an authoritative and allocative mechanism often contrary to larger structural influences. This mediary position allows ensemble buffers to usurp influence and resources from both "external" and nested agencies. For the ensemble itself, the social buffer acts as a constraint to social change.

Universality refers to a policy of providing services without regard to "arbitrary" criteria. In this particular study, the ability to pay for services has been adopted as a non-arbitrary criterion by which to discriminate between potential clients. The adoption of a universalizing policy
has been tied to the wealth structure of society and the market orientation (see Kamakahi, 1989b).

The health sector is a large conceptual rubric which includes a diverse array of services and sub-sectors. The health sector is a stratified cornucopia of ensembles, practitioners, and allied structures. The amorphous sector is characterized by internal technological and professional differentiation in which participation on the part of ensembles requires continual reproduction. The tertiary subsector (i.e., hospital subsector) requires much more continual upgrading than "lower" subsectors.

These generalizations concerning individual latent factors demonstrate the structuration of political-economic processes as realized through health ensembles themselves. Previous arrangements, however, exert an inertial influence upon further development. Continual shaping of the health sector is influenced by relative position of ensembles and other agencies.

**Inter-relationships Between Latent Factors**

The CBHE panel trajectories are a subset of larger processes that have occurred within the health sector at large. The individual components of the panel in essence defined their respective sectors to a large degree. It is with some confidence, then, that it is posited that processes ascertained within the panel reflect the larger
processes of the more extensive political-economic situations.

**Social Buffers and Universality**

The insulating tendencies of social buffers has been discussed previously. Universality in post-Kingdom Hawaii had meant the adoption of fee universality: i.e., discrimination in the provision of services with respect to the client's ability to pay.

For all the CBHEs, there has been demonstrated an inverse relationship between social buffers and universality. The presence of social buffers and their "nesting capacity" over the ensemble deterred the influence of universality. Only when the social buffers were shed (as in the case of Kapiolani Maternity Home and Queen's Hospital) was universality implemented in practice. For Queen's this meant recasting its mission statements (see Kamakahi, 1989c) and for Kapiolani Maternity Home it meant shifting the emphasis on the Native Hawaiian "race" toward the "human race" (see Yardley and Rogers, 1984).

The social buffers of ensembles nested entirely within trust estates has been prohibitive to institutional change. Both the Lunalilo Home and Liliuokalani Children's Center represent rather ominous mandates from the trust structures supported by complex political-economic concerns. In terms of universality, they have remained peripheral: maintaining
a Native Hawaiian focus within a larger universalistic political-economic milieu.

Social Buffers and Health Sector

The mediating effects of social buffers upon ensembles has consequences that affect them in terms of health sector position. Over time the CBHEs have each settled into a health subsector. The presence of social buffers, as policy influencing agents, has, for the most part, acted as an inhibitor toward core (i.e., tertiary) subsector participation.

The relationship between social buffers and health sector has been an inverse one. One aspect of this relationship worthy of mention is the rapid change in Hawaii's health sector after it's annexation by the United States. At that point, beginning in 1900, the same processes underlying health sector transformations in the U.S. began influencing Hawaii as well. In Hawaii, wholesale changes within ensembles were required for secondary and especially tertiary care subsector participation. The nesting of ensembles within social buffers served to peripheralize ensembles by inhibiting change within ensembles.

In general, the continual changes required for tertiary subsector participants is negated by the presence of nesting social buffers. Again, Queen's Hospital's continuance in
the tertiary sector was greatly enhanced when it could dissolve the lagging influence of the Queen Emma Trust even though the latter did not greatly impinge upon ensemble policy per se. The dissolution of the Hoola a me Hooulu Lahui allowed Kapiolani Maternity Home to transform itself into a community hospital: entering the tertiary sector in the 1920s.

The peripheralization of Lunalilo Home and the Liliuokalani Children's Center is partly due to their stability, arising from parameters prescribed within the trust instrument which created them, within continually changing milieu.

**Universality and Health Sector**

There has been a direct, positive relationship between universality and health sector position. The CBHEs that adopted the policy of fee universality by discarding their ethnic criteria were able to operate within the tertiary or core technological health sector.

For Queen's Hospital this transition came immediately following Hawaii's annexation by the United States. With a policy of universality, Queen's remained the foundation of the tertiary sector in the Islands. Kapiolani Maternity Home's transition from a maternal home into a women's hospital also followed a policy change toward universality. Beyond the CBHEs, Japanese Hospital became Kuakini Hospital.
changing its target population from a strictly Japanese community toward the community at large.

The political-economy of the health sector, especially the tertiary subsector, required universality as a prerequisite for participation. Relatively few restrictions, by comparison, were imposed upon the primary and secondary subsectors (e.g., private physicians, custodial facilities, asylums, etc.). For non-tertiary ensembles, policies could be varied since they, in general, required less resources and offered lower levels of care to their clients. State facilities were required to participate in the value system policies of "true universality" beyond fee universality.²

The Political-Economy of Health in Hawaii

The political-economy of Hawaii plays an important part in the study of health ensembles. Although it must be realized that ensembles participate in and in many instances create and define the political-economy of health, the political-economy of health extends much farther than any particular ensemble or group of ensembles. The legal statutes and restrictions upon the legitimation of certain

² The policy of "true universality" means equal access regardless of the characteristics which individuals possess. But when appended to a stratified wealth system and commodified health practice, "fee universality" is the result. In other words, only those that can afford to pay for services can gain access.
practices and practitioners presents a positive aspect of political-economic actions; actions that are outcomes of larger, sometimes diffuse, interest group conflicts.

The coupling of ensemble organization with political-economic strictures often reflects the degree of participation of the ensemble within the health sector. This coupling is affected by internal policy (or their interpretation of projects), the ensemble's nesting within social buffers (e.g., a trust estate, a corporation, allied boards), and the "demands" of political-economy of health restrictions.

In general, it has been found that the greater the coupling between ensembles and the political-economic canopy, the greater the ensemble's participation in the tertiary care subsector. And, that the continual participation of ensembles within the tertiary care subsector is predicated upon its acquiescence toward political-economic changes. The tertiary care subsector, then, is an arena for constant transformation on the part of participating health ensembles.

The primary and secondary health care subsectors require less coupling of ensembles with the political-economic parameters and policies. Much less change and fewer requirements are imposed upon primary and secondary subsector participants; and concomitantly fewer resources
for development are allocated to them and surveillance is generally more lax.

The interface between ensembles and the political-economy of health reflects an ongoing participation of ensembles in establishing their historical "identities".

The CBHEs as a Microcosm

The CBHEs, as a panel, represent a microcosm for studying social change in Hawaii: especially with regard to the transformation of the health sector. The differenciation among the ensembles represent generic trajectories of ensembles traversing changing political-economic and socio-cultural milieu.

The historical processes which brought macro motifs of wealth structures, universality, and fractal diffusion generated themes which were to be reproduced or bypassed by nascent ensembles. The non-recursive interpenetration of ensembles, interest groups, instrumentation, and so on provided a complex and varied slate upon which individual ensemble trajectories could be written.

The structure of the panel as well as the trajectory of the individual components reflected the extent to which ensembles were active participants in producing legitimized identities. Legal statutes, economic factors, health issues, organizational templates, professional guilds, bourgeois ideas or citizen outcries in themselves were not
sufficient in accounting for changes in ensemble behavior. Such models assume consistent motivation among actors within a constant milieu. This study revealed the volitional vocabularies of motive that were produced and reproduced within uneven "environmental" transformation. Reductionist and deterministic models, by implication, would not have explained or predicted the trajectory of individual ensembles.

The general structuration of the health sector, however, can be said to exist through the production of social order instanciated by health ensembles. This ongoing accomplishment of order is largely participatory and produced as is clearly demonstrated by this study of the Crown-Based Health Ensembles.
CHAPTER 8

DISCUSSION

Hoerderer: I'll lie when I must, and I have contempt for no one. I wasn't the one who invented lying. It grew out of a society divided into classes, and each one of us inherited it from birth. We shall not abolish lying by refusing to tell lies, but by using every means at hand to abolish classes.

Hugo: All means are not good.
(Sartre, 1949: 223)

This chapter reflects upon the study of the Crown-Based Health Ensembles (CBHEs) presented in the previous chapters. This study investigated health ensembles within the changing contexts of Hawaii's historical development. In this chapter, the following topics will be presented: (1) a summary of the project; (2) a discussion of the theoretical orientation employed; (3) limitations and possible extensions of the study; and (4) some concluding remarks.

Summary of the Project

This project has been a socio-historical investigation of four health ensembles immersed and participating within milieu of rapid political-economic and socio-cultural transformations. The Crown-Based Health Ensembles (CBHEs) represented a diffuse but important collectivity. They were focal philanthropic projects which introduced Western institutional practices to the Native Hawaiian population and were legitimized through the quasi-traditional ethnic aristocracy.
The major task of this dissertation was to provide an interpretive framework by which the CBHEs could be studied both as unique "historical individuals" and as participants in the larger processes of structuration. A Sartrean orientation was employed to highlight the changing characterization of ensembles as collectives in the production and reproduction of their own identities. The identities of ensembles are continually defined by the "goodness-to-fit" between the various levels of mediative mechanisms (both external and internal).

Of particular interest were substantial shifts in ensemble policy: or epiphanies (see Denzin, 1989). With regard to the CBHEs, these shifts involved changes in the policies of universality, the extent to which ensembles were nested within social buffers, and their position within the amorphous health sector. Information was garnered from public documents inclusive of newspaper articles, charters of incorporation and their amendments, legal statutes, judicial decisions, and ensembles publications. Because this investigation was primarily interested in public policy and the interrelationships between ensembles and external agencies, the use of publically available information was deemed suitable and sufficient.

It was found that the trajectories of the CBHEs were shaped by the nonrecursive relations between them and the complex web of external agencies: agencies which often
permeated into the policy-making body of the ensembles themselves. The stratification within the health sector was related to an ensemble's instanciation of political-economic perspectives/values. Likewise, the political-economic milieu was itself affected by internal and external influences. Internal influences included the organization of Westerners within the kingdom, the formation of guilds, the level of technology, and so on. External influences included the importation of contract laborers and diseases, the spread of foreign diseases within the Native Hawaiian population, the annexation of the islands by the United States, the implementation of the Hill-Burton Act, and so on.

The position of ensembles within the changing milieu of Hawaii could not be definitively reduced to the existence of any particular set of determinants. Rather, the processes of structuration were accomplished via a complex convergence of self-defined policies, externally legitimated parameters, and availability of resources. Health sector position was dependent upon the degree to which ensembles successfully mirrored political-economic arrangements.¹

¹ See Weick (1976) on loosely coupled systems and Robillard and Marsella (1987) regarding such arrangements and health services in the Pacific. There may also be a homologous parallel with chaos theory and the notion of fractals (see Gleick, 1987).
Toward a Non-reductionist, Non-determinist Orientation

The perspective this study employed was non-reductionist and non-deterministic. By non-reductionist it is meant that the trajectories of the ensembles were not attributed to a single level of analysis or a particular set of causal factors. Instead, the project attempted to demonstrate the inter-relations between levels of analysis and certain empirical characteristics. The complexity of the circumstances and the changing aspects of milieu were emphasized.

By non-determinist, it is meant that this investigation was not attempting to create a causal model that explained ensemble trajectories. Rather, the identification of correlative patterns or structures was used to evaluate and interpret ensemble trajectories. Political-economic and socio-cultural transformations as well as internal ensemble changes could alter policy outcomes.

Such an approach does not have to be functionalist; that is, it doesn't have to identify a set of a priori "needs" that must be fulfilled in order for ensembles to survive (see Parsons, 1951, 1963). This investigation has discarded the notion of "needs" and focussed instead upon structures produced and reproduced by the quasi-purposeful "goodness-to-fit" between ensembles and their various relevant environments. Systems, collections of
collectivities, construct and define their own requirements in vivo and not a priori.

This investigation did not accept the a priori distinction between the structural and the processural. This dissertation employed an orientation which attempted to discuss the processural development of structures over time. In this way, this study adopted the notion that the actual separation of structure and process is a theoretical fiction (see Sartre, 1976; Denzin, 1989; Giddens, 1981).

No predetermined propositions or hypotheses were specified or tested, no unitary orienting strategy was employed, and no formal methodological design was proposed. The investigation instead was organized around Sartre's framework for depicting practical ensembles with a substantive interest in four specific organizations immersed within a particular historical milieu. The study was primarily interested in constructing a "grounded" interpretive discussion that would account for the similarities and differences between the CBHEs and which would serve to develop a substantively informed theoretical position reaching far beyond this particular set of ensembles.

The underlying premise, then, was to develop a substantively based depiction of the CBHEs from a flexible theoretical orientation: one which did not overdetermine the data. Although the information was undoubtedly
structured by tacit theoretical considerations, the Sartrean-structuration approach allowed ample room for the data to inform the interpretation.

Three working assumptions, though, should be stated explicitly. First, it was assumed that there is an indeterminacy in ensemble trajectories which is partly material (see practico-inert) and partly ideological (meaning constructed). Ensemble identities were seen as malleable and negotiated within concrete material and meaning contexts.

Secondly, it was assumed that there exists at any given time a complex web of material and meaning contexts which are differentiated and stratified with regard to political-economic milieu. A given ensemble is simultaneously immersed within many relevant, and irrelevant, environments and may traverse contexts to "re-locate" itself within this morass. Social change, and social stability for that matter, require ensembles to continually monitor and adjust.

Third, and finally, it was assumed that ensembles themselves were complex entities of interpenetrating interests rather than discrete, homogeneous units of analysis. Thus, ensembles are depicted as malleable entities immersed within complex milieu; they are neither internally nor externally programmed to follow a predetermined course of action. Action must be understood contextually and motivationally.
These three working assumptions characterize the major thrust of the project which was to identify the social construction of ensemble structuration within the appropriate vocabularies of motive and to interpret such events within a Sartrean framework.

Limitations and Possible Extensions of the Project

Every theoretical/methodological orientation focusses its attention upon certain issues and interpretations in lieu of others. The Sartrean approach employed within this dissertation has focussed primarily upon ensemble policies and policy-makers, legal identities and constraints, and social tranformation of contexts. An historical investigation employing public documents was chosen.

Although the approach was argued to be the most appropriate given the meta-theoretical and substantive concerns of the author, certain limitations should perhaps be elucidated. First, the conception of the Crown-Based Health Ensemble (CBHE) construct was a theoretical abstraction, much like an "ideal type", which served to direct attention toward certain shared features of these four ensembles. The "arbitrary" selection of characteristics may be seen as a derivative, post hoc construction rather than a theoretical, a priori template. Obviously, the creation of the CBHE notion produces, perhaps overdetermines, characteristics for empirical comparisons.
Does the construct in fact create an impromptu measuring stick for disparate and unrelated institutions?

Apparently there is some merit to this line of criticism. The CBHE ideal type was assumed to be a template by which comparisons could be accomplished. It was created and proposed by the author as a means by which social transformations of diverse ensembles within rapidly changing contexts could be managed and explicated. The template itself, though, was itself informed by theoretical and substantive concerns: being a theoretical device for comparison rather than an "arbitrary", hence a-theoretical, device which superceded theoretical and substantive concerns. There is no doubt that the CBHE template was biased. However, its biases were focused upon theoretically and substantively relevant issues of concern as are all investigative and methodological tools.

A second point of criticism may center around the investigation's concern with epiphanies/change/discontinuities/transformations. The use of the Sartrean framework for practical ensembles as an interpretive collection of ensemble "types" posited no specific progression of ensemble trajectories by which such transformations could be understood. Was there any reason that epiphanic change and a Sartrean orientation coincided? Or would the investigation of such change have been served at least as well by another orientation?
The Sartrean orientation was adopted because of its flexibility and because it provided a means by which ensembles could be characterized with regard to public declarations or public actions of ensemble re-definition. The Sartrean "types" were employed as interpretive devices toward the end of creating an adequate depiction of ensemble and extra-ensemble relations. It does not tie an organization or any collectivity to a single pervasive characterization.

A third criticism concerns the shifting in focus between various aspects of ensembles rather than remaining with a single, well-defined unit of analysis. The shifting from one aspect to another of ensembles presents, at times, a melange of concerns which may or may not seem to coincide with one another.

The more diffuse, "multi-level" strategy was opted for in this investigation to capture the complexity within, without, and between ensembles. The interest in this study was not to provide a presentation of a consistent unit of analysis, but rather to create an informed interpretation of ensemble transformation and stability. The strategy of treating ensembles as diffuse and complex entities served to provide a foundation for understanding how ensemble's continually produced social identities within self-constructed and externally-constructed parameters. The
multi-level orientation allowed for the fleshing-out of complex issues and outcomes as well as their implications.

A fourth area of criticism focuses around the use of only public documents: e.g., charters of incorporation, legal statutes, newspaper articles, and so on. This almost exclusive reliance on public text can be seen as representing a methodological bias contrary to an in-depth delving into actual conflicts of interest and motivations which would be better garnered through an investigation of private documents such as organizational minutes of meetings, diaries and personal journals, interviews, and so forth. The reliance on public documents presents, perhaps, an implied rather than an actual characterization of ensemble transformations.

This criticism merits response for it addresses the heart of the study: that is, how valid is the data with respect to the generated interpretations? Obviously, the author would ideally have knowledge of, access to, and employ all data relevant to a given topic; that is, of course, quite simply impossible. The use of personal documents of relevance to the investigation would certainly have enhanced the investigation; here, the problems of knowledge of existence and access to information come to the fore as do issues of time constraints. However, it must be stressed that this investigation was interested in the social transformation of health ensembles within the context
of political-economic and socio-cultural milieu. As such, the information of primary interest and concern were public documents which stated explicitly, or implicitly, shifts in either the ensembles themselves and/or related agencies. Public declarations of policy changes were often appended amply in the tabloids of the day by official as well as personal accounts and disclaimers. At other times, reflexive documents were available at repositories of documents: e.g. the Hawaii State Archives. The study itself was concerned with social transformations revealed in the public declarations of ensembles viz-a-viz relevant contexts. The data suited this purpose well; and, it may be argued, provided consistent and relatively complete coverage of all ensembles.

A final point of criticism which will be discussed here regards the use of such a small sample for making generalizations about the historical population of health ensembles that have existed in Hawaii. In chapter 7, three latent factors were identified and then various generalizations were espoused regarding the relationships between these factors with the population of health ensembles in Hawaii (and perhaps, in general). Is there evidence to demonstrate that such generalizations are implicated (and warranted) from a sample of four, arguably unique, institutions?
The investigation began by arguing that at the time of their creation, the CBHEs represented unique institutions for the definition and dealing of health/social problems in Hawaii. Specifically, they were philanthropic enterprises which employed a Western template for defining and addressing problems of health and well-being of the Native Hawaiian population. However, subsequent events, most notably the further instanciation of the wealth structure and the annexation of the islands by the United States, served to encompass the ensembles within well-defined locations of a heterogeneous, but integrated, field. The location of a health ensemble relied on its ability to locate itself within the political-economic rubric: specifically, the political-economy of health. The structuration of the health sector was reified in the relationship between health ensembles, health related agencies, and political-economic parameters. As the political-economy of health developed historically, the CBHEs could be conceptualized as entities participating within a fabric of reified locations. Thus, while we can study the CBHEs as unique "historical individuals", it is also the case that they display health (sub)sector identities of a category which they share with like-situated ensembles and which concomitantly distinguish them from differently-situated ensembles. The larger social identities are reified, acknowledged typifications that
apply to categories of ensembles. The trajectories of the CBHEs as a theoretical sample in no way detracts from their informing us as substantive examples for grounded theoretical and empirically derived generalizations.

Ensembles are simultaneously complex aggregates, unique "historical individuals", and participants in category memberships. This study attempted to capture these various facets of the CBHEs as they related to policy changes and health services.

**Concluding Remarks**

This study attempted to create a theoretically informed, substantive discussion of four health ensembles. While there were highly descriptive discussions, the major thrust of the project was guided by issues of theoretical import; theoretical concerns undoubted textured the course and content of depictions.

Generalizations produced by this investigation of the CBHEs were derived from interpretations of the comparable data. Although the CBHEs represent a small comparative sample, as a theoretical sample they are indicative of more ubiquitous structuration processes of the larger, integrated political-economic field. With regard to the CBHEs, the generalizations are depictions of structuration. With regard to possible extensions of these generalizations, the statements may be conceived of as tentative propositions to

250
be explored at some later time. It is proposed here that the concepts of social buffers, universality, and sector position are useful theoretical devices for studying the differentiation between health ensembles. Such concepts would likely be of assistance in any study of ensemble/institution/organization policy: especially those involving contexts of rapid and/or significant social transformations.

It is hoped that this study has contributed to the general area of medical sociology, especially as it relates to health organizations. It has been informed by several historical studies of health organizations (see Foucault, 1973; Brown, 1979; Rothman, 1971) and the political-economy of health (see Starr, 1982; Navarro, 1976, 1978; Doyal, 1975). The major contribution of this study to the literature is the socio-historical investigation of health ensembles in Hawaii: a setting which provides a context for an ideal natural experiment in the study of social change. The historical study of health ensembles and health policy in Hawaii has been a long neglected area of study: an area this investigation has only begun to address.
BIBLIOGRAPHY

Adler, Jacob (ed.)

Adler, Jacob and Robert M. Kamins

Althusser, Louis

Amalu, Samuel
1983 The Royal Estate of People's King was Plundered, Honolulu Advertiser, January 30.

Anderson, Perry

Armstrong, William
1904 Around the World with a King. New York: Stokes.

Arnold, Harry L. Jr.

Aron, Raymond

Aronson, Ronald

Bailey, Kenneth D.
Bailey, Paul

Barringer, Herbert and Patricia O'Hagan
1989 *Socio-Economic Characteristics of Native Hawaiians.* Honolulu: Alu Like.

Becker, Howard S.

Beechert, Edward D.

Blaisdell, Kekuni

Blount, James

Blumer, Herbert

Board of Health
1868 *Board of Health Reports.* Honolulu: Kingdom of Hawaii.

Bolles, Elizabeth

Bremner, Robert H.

Brown, E. Richard
1979 *Rockefeller Medicine Men.* Berkeley: University of California.
Brown, R.H.  

Busch, Thomas  
1972 Sartre: From Phenomenology to Marxism, Research in Phenomenology, 2, 112-120.  

Catalano, James  

Catton, Margaret M.L.  

Caws, Peter  

Chinen, Jon J.  

Connell, R.W.  

Couch, Carl J.  
1984 Constructing Civilizations. Greenwich, CT: JAI.

Couch, Carl J. and Robert A. Hintz (eds.)  
1975 Constructing Social Life. Champaign, Ill.: Stipes.

Craib, Ian  

Danielson, Ross  
Daws, Gavan

Daws, Gavan and George Cooper

Day, A. Grove

Denzin, Norman K.

Desan, Wilfred

Dole, Sanford B. (Collection)
1880 *Letter to the Supreme Court Justices, November 26*, (Hawaii State Archives).
1885 *Accounts of Land Sold at Auction, April 27*, (Hawaii State Archives).

Dorton, Lilikala

Doyal, Leslie

Duncan, Hugh D.

Flynn, Thomas R.

Foucault, Michel
Freidson, Eliot (ed.)

Gast, Russ H. and Agnes Conrad

Gibson, Walter M.
1885 *The Leper Settlement in Dedication of the Kapiolani Home* (Honolulu: Advertiser Steam).

Giddens, Anthony

Gillan, Garth J.

Gleick, James

Goffman, Erving

Gottlieb, Roger S. (ed.)

Greer, Richard A.
1969 *The Founding of Queen's Hospital, Hawaiian Journal of History*, 3, 110-145.

Gugelyck, Ted and Milton Bloombaum
1979 *Ma'i Ho'oka'awale: The Separating Sickness*. Honolulu: University of Hawaii Foundation and the Ma'i Ho'oka'awale Foundation.

Gutmanis, June

Halford, Francis John
Hamilton, Robert W.

Handy, E.S. Craighill and Mary Kawena Pukui
1972 The Polynesian Family System in Ka'-u, Hawai'i. Rutland, Vt.: Tuttle.

Hanley, Mary Laurence and O.A. Bushnell

Hawaiian Gazette
1887 The Lunalilo Home, December 27.
1889 Lunalilo Home, February 2.
1890 Maternity Home, June 17.

Hawaiian Spectator
1838 Hospitals, 86-89.

Hayim, Gila J.

Hendley, S.

Honolulu Advertiser / Pacific Commercial Advertiser
1860 Untitled, December 6.
1871 Native Physicians, July 15.
1881 The Lunalilo Home: Ceremony of Laying the Foundation Stone, April 16.
1883 Opening of the Lunalilo Home, April 3.
1890 Maternity Home, June 16.
1891 Lunalilo Home, July 31.
1900 Queen's Hospital Financial Status, July 30.
1901a May Lose It's Money, July 31.
1901b Hospital Gets Cash, August 1.
1924a Lunalilo Home in Deplorable Shape - Report, February 16.
1924b Re: Lunalilo Home, February 19.
1927a Fifty-Two Aged Hawaiians in Crumbling Lunalilo Home Cheerful Despite Discomfort, January 3.
1927b Lunalilo Home Transfer Given Court Approval, May 28.
1931 Untitled, May 9.

257
1939  Queen Emma Estate Dissolution Protested, July 16.
1940  Sixty Years Ago - 1880, October 22.
1944a Plan Afoot to End Queen Emma Trust May Stir Trouble, November 14.
1944b Hemenway Defends Plan to End Trust, November 17.
1944c Forty Years Ago - 1904, January 31.
1946b Lunalilo Accounts, January 16.
1946c Trustee Named, January 16.
1947  King Lunalilo's 112th Birthday Feted Here, February 1.
1950  Alex Smith Named Manager, December 1.
1951  Mrs. Poire Named to Estate Board, May 24.
1955  House to Vote Lunalilo Home Appropriation, March 31.
1957  70 Hawaiians Round Out Lives as 'Guests' of King Lunalilo, April 14.
1959  Queen Kapiolani Liked Babies, June 23.
1966  AG Report Criticizes Lunalilo Trustees, July 22.
1967  Queen Emma Trust Abolished, March 8.
1969  Queen's Medical Center Expansion Gets Hearing, September 17.
1970  100 Years Old and Growing, August 23.
1982  Ground to be Broken for Condo, September 22.

Honolulu Star-Bulletin
1927  Jarrett May Be Manager of Lunalilo Home, September 14.
1929a Former Home of Organization is to be Abandoned, March 26.
1929b Ground Broken for Kapiolani Home Last Year, March 26.
1929c Accommodations Sufficient for Fifty Mothers, March 26.
1929e Hawaiian Queen was Founder of Maternity Home, March 26.
1929f New Maternity Home Dedicated Tuesday, March 26.
1934  Trust Estate Seeks to Help Orphans Here, September 17.
1937b Untitled, June 30.
1939  Hodgson Files Objection to Ending Trust, July 15.
1940 Riches for Hawaii's Needy, September 7.
1944 Hawaiian Trust Asks City to Pay Overdue Bills Totaling $4,500, September 13.
1948 Untitled, February 21.
1949b Lunalilo Home Officers Mum on Judd Resignation, June 6.
1949c Nelson Spencer Named to Head Lunalilo Home, June 15.
1950 Queen Emma Estate Assets Given to Queen's Hospital, November 20.
1952 Lunalilo Home Superintendent Job Still Open After Squabble, February 21.
1954 Judd Named Trustee of Lunalilo Estate, March 11.
1955a T.H. Aid to Lunalilo Home Ruled Illegal, March 29.
1955b The King's Gift, January 22.
1960 With a Song in Their Hearts, December 25.
1966 New Children's Center is Dedicated Today, December 9.
1971 Estate to Enter Housing Field, January 12.
1972 Two Hospitals Plan Unique Merger, August 29.
1978 $2.3 Million Freed for UH Medical School Facilities, June 12.

Houston, Victor S.K.
1939 Medical Care Needed For Hawaiians, lectures presented before Hawaiian Civic Club, September (in Hawaiian and Pacific Room, Hamilton Library, University of Hawaii at Manoa).
1950 The Queen's Hospital, in The Honolulu Advertiser, December 19-26.

Ikeda, Kiyoshi (ed.)

Imboden, Roberta
1987 From the Cross to the Kingdom. San Francisco: Harper and Row.

Jay, Martin

259
Kamakahi, Jeffrey J.

Kamakahi, Jeffrey J. and Albert B. Robillard

Kamakau, Samuel

Kanahele, George S.

Kapiolani Home of the Hooulu and Hoola Lahui Society
n.d. Charter of incorporation. (Hawaii State Archives: folder 138D2).

Kauka, Iris and Noreen Mokuau

King, Pauline (ed.)
Kingdom of Hawaii
1855 An Act to Institute Hospitals for the Sick Poor, Session Laws, 20.
1859 An Act to Provide Hospitals for the Relief of Hawaiians in the City and County of Honolulu and Other Localities, Civil Code, 433.
1860 An Act in Aid of the Queen's Hospital Corporation, Session Laws, 26.
1874 In the Matter of the Estate of His late Majesty Lunalilo, Hawaiian Reports, 519-522.
1879a In the Matter of the Estate of His late Majesty Lunalilo, Hawaiian Reports, 162-165.
1879b Smith v. Wilder, Hawaiian Reports, 228-232.
1880 Lunalilo Trustees v. Haalilio, Hawaiian Reports, 640-645.
1885 An Act to Institute Hospitals for the Sick Poor, Session Laws, 20.
1892 An Act to Provide for the Disposition of Hospital Tax Funds, Session Laws, 59.

Kronenfeld, Jennie J. and Marcia L. Whicker

Kuykendall, Ralph S.

Laing, R.D. and D.C. Cooper

Larson, Nils P.

Lave, Judith R. and Lester B. Lave
Liliuokalani Trust

Linnekin, Jocelyn
1984 Land Relations and the Status of Women in Post-Contact Hawaii. (Hamilton Library, University of Hawaii - Manoa).

Lunalilo Home

Lydecker, R.C. (ed.)

Malo, David

McBride, William Leon
1980 Social Theory at the Crossroads. Pittsburg: Duquesne University.

Mead, George Herbert
1959 The Philosophy of the Present. Seattle: Open Court.

Mennell, Robert L.

Merleau-Ponty, Maurice

Meyer, J.W. and B. Rowan
Mills, C. Wright

Morris,

Native Hawaiian Study Commission

Navarro, Vicente
1978 *Class Struggle, the State, and Medicine*. New York: Prodist.

Nebelung, R.G. and R.C. Schmitt

Parsons, Talcott

Polynesian, The
1840 Hospitals, 74.
1859a Untitled, April 30.
1859b "His Majesty's Speech Proroguing the Legislature", May 7.

Poster, Mark

Provisional Government of Hawaii
1894 The President Ex Rel. The Queen's Hospital v. Castle, *Hawaiian Reports*, 576-584.

Pukui, Mary Kawena et al.

Pukui, Mary Kawena and Samuel H. Elbert
Pukui, Mary Kawena, E.W. Haertig, and Catherine Lee

Queen's Hospital Corporation
1859 Charter of Incorporation of the Queen's Hospital, June 16, (Hawaii State Archives).
1909 Petition: In the Matter of Amending the Charter of the Queen's Hospital, June 23, (Hawaii State Department of Commerce and Consumer Affairs).

Roberts, Helen

Robillard, Albert B. and Anthony Marsella (eds.)

Rosen, George

Rosenberg, Charles E.

Rothman, David J.

Sartre, Jean-Paul
1948 *Anti-Semite and Jew.* (George J. Becker, trans.). New York: Schocken.

Schmitt, Robert C.

Sheridan, James F., Jr.

Simmel, Georg

Skocpol, Theda (ed.)

Snedecker, G.

Stack, G.J.
1971 Sartre's Dialectic of Social Relations, Philosophy and Phenomenological Research, 31(3), 394-408.

Stannard, David E.

Starr, Paul

State of Hawaii
1967 Amendment of Charter of Incorporation for Queen's Hospital, (Hawaii State Department of Commerce and Consumer Affairs).

265

Takaki, Ronald

Talmadge, Mary Christine

Territory of Hawaii
1900 Rooke v. The Queen's Hospital, Hawaii Reports, 375-408.
1901 In the Matter of the Estate of W.C. Lunalilo, Hawaii Reports, 317-318.
1904 In Re The Queen's Hospital, Hawaii Reports, 663-667.
1907 Kapiolani Home v. Lewers and Cooke, Hawaii Reports, 497-499.
1908 The Queen's Hospital v. Cartwright, Hawaii Reports, 52-65.
1932 Kapiolani Hospital v. Wodehouse, Hawaii Reports, 32, 489-503.
1936 Kapiolani Hospital v. Wodehouse, Hawaii Reports, 33, 846-860.
1942 Hite v. Queen's Hospital et al., Hawaii Reports, 36, 250-314.
1950 The Queen's Hospital v. Hite, Hawaii Reports, 494-521.
1957a Act 59 - Hospital and Medical Facilities Construction, Laws of the Territory of Hawaii, 49.

Thrum, Thomas
1918 Death, Lying-in-State, and Obsequies of Queen Liliuokalani, Thrum's Hawaiian Annual, 102-109.
Tolbert, P.S. and L.G. Zucker

Turner, Bryan S.

Vogel, Morris J

Wallerstein, Immanuel

Warnock, Mary

Weber, Max

Weick, K.E.

Weinerman, Edwin R.
Wegner, Eldon L. (ed.)

Wrong, Dennis

Yardley, Maile and Miriam Rogers

Yovel, Y.
1979 Existentialism and Historical Dialectic, Philosophy and Phenomenological Research, 39(4), 480-497.

Zalburg, Sanford

Zucker, L.G.