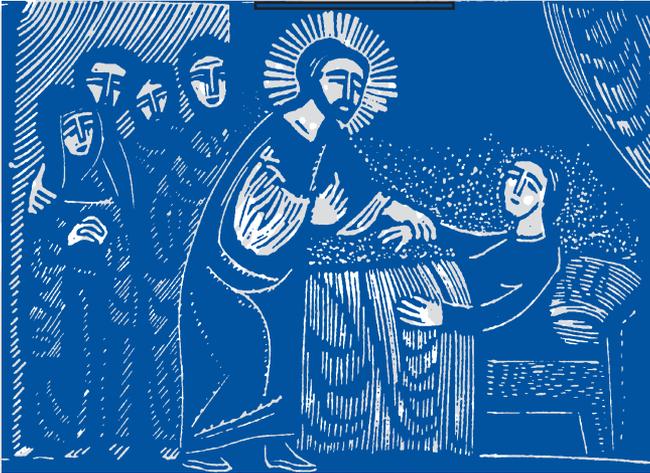


The Mission to Care for the Sick



The Development of Catholic
Health Care Facilities and
Their Evolution in New Brunswick

Michael McGowan

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ABOUT THE AUTHOR

Rev. Michael McGowan was born in Saint John, New Brunswick on June 4, 1952. He attended the University of New Brunswick, graduating with a Bachelor of Arts Degree in 1977. Subsequently, he studied theology at Saint Paul University, Ottawa, where he obtained the Bachelor of Theology degree in 1980. Ordained to the priesthood on May 7, 1981, he has served as associate pastor and pastor of a number of parishes in the Diocese of Saint John. Father McGowan has acted in a number of capacities in the ecclesiastical tribunal in Saint John. In 1994 he began studies in Canon Law at Saint Paul, obtaining the Licentiate Degree in 1996. In that same year he began doctoral studies, obtaining his Ph.D. (Canon Law) in 1998. The title of his doctoral dissertation was *The Canonical Status of Catholic Health-Care Facilities in the Province of New Brunswick in the Light of Recent Provincial Government Legislation*. He is also the author of the recent publication *Governance/Sponsorship Models of Canadian Catholic Health-Care Organizations*. At the present time he serves as ecclesiastical judge of the Halifax Regional Matrimonial Tribunal, canonical advisor to the New Brunswick Catholic Health Association and canonical advisor to the Bishop of Saint John. In the fall of 1999 he plans to begin teaching at St. Thomas University, Fredericton.

INTRODUCTION

For generations, people of good will and faith have undertaken the important apostolate of caring for the sick. The compassion, concern and care extended to those afflicted with sickness and suffering are considered by the Catholic Church to be works of charity and mercy, integral parts of its mission.

Among the various ways of caring for the sick, the Catholic Church has established health care facilities, as a sign of hope and a living witness to the presence and power of a healing God. These facilities continue in our own day to follow a “tradition of excellence, dedicated service and unselfish caring”¹ throughout Canada. They are an integral part of Canada’s health care system, instrumental in providing both leadership and service, as well as accessible and quality health care to all citizens.²

The purpose of this booklet is to trace the development of Catholic health care facilities and in particular those in the Province of New Brunswick. These facilities came about in response to various needs and situations, among them, the care of victims of epidemics and concern for immigrants. Part One of this work will examine the early development of health care facilities. It will provide a synopsis of its pre-biblical roots, followed by a scriptural reflection on sickness and suffering in both the Old and New Testaments. From its early beginnings of extending hospitality and assisting pilgrims and travellers, facilities during Apostolic times and in the early Church laid the foundations for further development of the health care apostolate. This will be followed by an overview of the growth of such facilities between the sixth and seventeenth centuries.

The development of Catholic health care facilities in Canada will form the basis of Part Two. By examining the early years of the Church’s involvement in health care, especially the contributions made by various religious institutes, an appreciation will be gained for the vital role the Church has played in the overall development of health care facilities in all regions of the country.

Finally, Part Three will deal specifically with health care in the Province of New Brunswick and the development of Catholic health care facilities

therein. Especially important will be the significant role played and the substantial contributions made by the religious institutes in response to exercising this essential work of caring for the sick throughout the province.

I. EARLY DEVELOPMENT OF HEALTH CARE

A. Pre-Biblical Roots

Common to peoples of all ages and societies is the importance given to the physical and mental well-being of the human person. Society has gone to great measures to treat and prevent illnesses of all types and control the spread of disease. With the use of various medicines and practices, humanity has responded remarkably well in the pursuit of the noble and lofty calling to provide care to the sick, the suffering and the dying. It could probably be said that almost every grouping of people has built and dedicated special facilities of one kind or another for the sole purpose of providing health care.

The care of the sick, the prevention of disease, the comforting of the suffering and the consolation of the dying have caught the fascination and imagination of each generation and at the same time presented a challenge. Long before the birth of Christ, the ancient peoples of the Far East – in Ceylon (now Sri Lanka) and India at the time of Buddha – had facilities set apart for the caring and treating of sickness. They manifested essential characteristics in the provision of care, characteristics still in operation today. These early facilities stressed the importance of hygiene, dietary practices and treating the patient with kindness and respect.³

Throughout the Greek⁴ and Roman Empires,⁵ temples built to the gods of health were a common occurrence. Facilities to treat the sick were usually associated with these places of devotion and pilgrimage. Important in the Greek culture and society of the time was the impressive and monumental temple to Aesculapius, the Roman god of medicine, identified with the Greek god Asclepius, a place where many sought healing.⁶

Care and prevention of sickness were found not only in the ancient

Greek and Roman empires. The healing arts, now known as medicine, were also practised in the ancient cultures of Egypt, Babylonia and China.⁷ Through the use of various remedies, natural products and practices, such as herbs, needles, and acupuncture, the sick received treatment for their ailments. Modern health care methods and practices owe a great deal to the ancient cultures in developing the quality health care we are accustomed to today. Present even in modern medicine are the symbols of ancient medical practices, especially the taking of the *Hippocratic oath* and continued use of the *caduceus*, the age-old symbol of the physician.⁸

B. Scriptural Reflections on Sickness and Health

Judeo-Christian literature abounds with stories of life, sickness, healing, and death. Through their reflection on these various themes, the Jewish and Christian faith traditions have responded in the face of illness by extending care, concern, compassion and relief to those afflicted. In scriptural times, fever, leprosy, paralysis, dumbness, atrophy, haemorrhage, deafness and speech impediments, blindness, epilepsy, infirmity, dropsy, and a severed ear were some of the illnesses afflicting humanity.⁹

From the very first pages of the Old Testament a vision of serenity, peace and harmony is portrayed. Health and happiness are the order of the day. All is good — all is very good. However, humanity's disobedience very quickly shatters that relationship with the Creator. Because of that disobedience, sickness, suffering and death become a part of the landscape. Nevertheless, God remains constantly faithful, earnestly wanting the restoration of harmony in creation. Despite humanity's unfaithfulness, God enters into a covenant relationship with His creatures beginning with Abraham and Sarah and their descendants.¹⁰

The biblical themes of life, sickness, suffering and death are taken up again in the Book of Exodus. There God is portrayed as the Ever-Faithful One, the One who promises freedom from slavery, bondage and oppression. Under the capable leadership of Moses, Israel journeys to the land of milk and honey. This central event in the life of Israel continued to show forth God's constant desire to restore health and life in the face of misery.¹¹

Belief in life is reaffirmed in Deuteronomy. A challenge is issued to Israel to make a choice, a choice between life and death.¹² Again God is portrayed as the God of the living, not of the dead. God is the One who restores to health and prosperity. In this promised new kingdom, the new creation, humanity will be freed from sin, sickness, suffering, and most of all, from death.¹³

The hymns of Israel contained in the Book of Psalms sing about the human experiences the people encounter. Loss of life is seen as a cause for lamentation, as a punishment for unfaithfulness to the covenant. On the other hand, restoration to health is a time for praise and thanksgiving, a time of confidence in future deliverance and healing.¹⁴

Finally, in the Old Testament literature, the writings of the prophets, especially Ezekiel and Isaiah deal with the themes of sickness and healing. The outstanding image used by the prophet Ezekiel is the flowing stream of life-giving water.¹⁵ In his writings, the prophet Isaiah concentrates on the Suffering Servant theme. The Suffering Servant of Yahweh is portrayed as the powerful witness of God's covenant, of God's loving and life-giving relationship with His people. Through his suffering, through his wounds, we are healed.¹⁶

The Old Testament can be summed up in one word, the ancient Hebrew word *Yeshu*, meaning salvation. This one word portrays a new image of God, as the God who is the giver of life and health, the restorer of the work of creation. "According to the Bible, salvation is a moment of total healing where sin and suffering are taken away by God's health giving power for those who follow His word."¹⁷

The New Testament gives great prominence to Jesus' ministry of healing. The literature abounds with breathtaking examples and stories of care and compassion, and restoration to health of those afflicted with sickness of one kind or another. The sensitivity, concern, and tenderness of Jesus toward the sick and suffering remain steadfast as witnessing to the healing presence of God. The New Testament scriptures portray Jesus not only as a great teacher, but also as a healer, as the Divine Physician. He put into action what he preached, he reached out and in solidarity he touched, he restored human dignity, he gave health and life to those he encountered at a vulnerable, crisis time in their lives.

Jesus viewed sickness and suffering as an evil, as a consequence of the broken relationship between Creator and creature, a turning away from God, a sign of Satan's dominion over humanity.¹⁸ However, throughout his many encounters, Jesus felt pity and compassion for the weak and fragile in society. He took affirmative action in the face of sickness and suffering and was able to bring to a moment of doubt and darkness, the presence and power of a healing God. Sickness, suffering and death could be overcome and Jesus brought about that belief, that possibility. He showed that he not only had power over sin, but that he also had power over sickness.¹⁹ In Jesus, good would triumph over evil, life would triumph over death. The healing power expressed and displayed in Jesus was the powerful sign of the beginnings of the kingdom of God.²⁰ In and through Jesus, God touched and transformed sickness which was given a new and much deeper meaning. Sickness, suffering and death were to be of redemptive value for humanity.²¹

L. Dufour states in his writing on this biblical notion that "sickness is a symbol of the state in which sinful man finds himself; spiritually he is blind, deaf, paralyzed. The cure of the sick man is, therefore, also a symbol. It represents the spiritual cure that Jesus came to work in men."²²

The ministry and example of Jesus is the sacrament, the sign of God's healing power. Jesus is the one who takes on suffering and transforms it, he gives suffering value and restores the person to harmony with the Creator.²³

C. Apostolic Times and the Early Church

The apostles were bestowed with the authority to carry on the mission of Jesus. They were made sharers in the work of healing. They continued to be the signs and witnesses of God's powerful presence in the world.²⁴

Wherever they went, the teaching and spreading of the gospel was always accompanied by concrete expressions of concern and care, especially toward those afflicted with illness.²⁵ The most powerful testimonies of the healing ministry of the apostles are attested to in the Acts of the Apostles.²⁶ Saint Paul in his writings speaks especially of the gift of healing,²⁷ a gift given for the building up of the community — the Church. From the time of the apostles, the healing apostolate has been an integral and essential component of the Church's mission. This apostolate has been exercised and concretized in three basic ways down through the ages:

- miraculous cures;
- prayer, anointing with oil, laying on of hands; and
- through the visible expression and witness given by the founding of health care facilities.²⁸

F. Cleary notes in his study on health care and the Church that, "Christianity is unique for institutionalizing (health care) and making it serve as a formally religious witness to the world. Nowhere else was care for the sick so widespread, so well-organized, and so self-sacrificing."²⁹ What we have come to appreciate and expect from modern health care is firmly rooted in the very beginnings of Christianity and the ministry of the first apostles.³⁰

Following the passing of the last apostle, the early Church continued the ministry of caring for the sick. Hippolytus, writing in the second century, portrayed Christians as concerned and caring for the sick in carrying on the healing work of the apostles.³¹ The Apostolic Constitutions, the earliest liturgical record of the Church, provided for the installation of exorcist and healer in the Christian community.³² Also included in the liturgical practice of the time was the prayer for the power of healing at the ordination of a priest.³³ Julian the Apostate, writing in the fourth century remarked, "Now we see what makes Christians such powerful enemies of our gods. It is the brotherly love that they manifest toward strangers and toward the sick and the poor."³⁴

The origins of health care facilities are deeply rooted in the Christian virtue of hospitality. The etymology of the word “hospitality” comes from its Latin roots “hospe”, meaning host. From early times, hospices have provided care and comfort to the traveller, help to the poor and needy, solace and concern for those afflicted with sickness, assistance to the elderly, homes for the orphans, the abandoned, and the widow.³⁵ Another factor in the promotion of the virtue of hospitality and the care of the sick was the development of the order of deacon³⁶ in the Church. The *diakonia* would provide *hospitality* [*hospitalitas*] to those needing it. This ministry of service could be exercised in various ways. However, four stand out in the development of the health care apostolate in the Church:³⁷

- establishment of inns for travellers (*xendochia*);
- establishment of infirmaries (*nosocomia*);
- establishment of foundling homes (*brephotrophia*);
- establishment of homes for the aged (*gerocomia*).³⁸

J. Casey, in her book on the theological reflections of the health care apostolate, states that “each of these involved a concern for health, but the inns for travellers and the infirmaries were the forerunners of systematic health care. The most important function of the inns was to shelter the sick.”³⁹ These facilities for caring for the sick and offering assistance quickly gained prominence in the Church. In 335 A.D., a Decree of the Emperor Constantine ordered the systematic establishment of health care facilities at Rome, Constantinople and Ephesus and in other parts of the Empire.⁴⁰

By the latter part of the fourth century, 370 A.D., St. Basil the Great had founded a large facility near Caesarea in Cappadocia. This became the model for the Christian hospital. Gregory of Nazianzus referred to this institution as a place where illness becomes a school of wisdom, where disease is regarded in a religious light, where misery is changed to happiness, and where Christian charity shows its most striking proof.⁴¹

D. Post-Apostolic Times

1. Sixth to Eighth Centuries

For the most part during the period of the VIth and VIIIth centuries, health care facilities were closely aligned to the local cathedral or monastery. The main emphasis of the time was placed on the spiritual well-being of the sick and their physical state. During this period the great health care institutions such as Hôtel-Dieu in Lyons (542) and Hôtel-Dieu in Paris (660) were established. As the different facilities expanded throughout the continent, usually under the direction and vigilance of the local bishop, the need for specific juridical regulations became necessary, especially in regards to their organization.

2. Ninth Century

The ninth century could be described as the age of monastic medicine. With the continued interest and flourishing of monastic life, the virtue of hospitality quickly became one of the common features of monastic tradition. With the virtue of hospitality came the interest in the practice of medicine by the monks and their association with it. At times during this period they would have been among the very few individuals considered qualified to provide the necessary treatment for illnesses.

Monks, especially the Benedictines, very rapidly became influential in the science of medicine and its sub-branches.⁴² The monastery became the basic health care facility⁴³ due to three factors. First, the monastery usually had an *infirmitorium*, where the sick could receive proper and adequate treatment for their affliction. Second, besides the *infirmitorium*, the monastery would have a pharmacy or dispensary where the necessary medications used in the treatment of illness were readily available. Finally, the monastery garden not only produced the required foods for the monks and visitors, but produced the various kinds of herbs used in the preparation of medications. During the ninth century the monastery functioned as one of the earliest facilities devoted not only to hospitality but to the integral work of caring for the sick. The monastery and its facilities soon became a virtual monopoly as far as the practice of medicine was concerned.⁴⁴

3. Middle Ages

The Middle Ages, perhaps more than any other period, influenced the religiosity of the health care apostolate. The first predominant factor

during this time was the rise of the Crusades. With the Crusades a new personality in health care came forward — the military orders.⁴⁵ The Knights Hospitallers of St. John, also known as the Order of Malta, soon became the most visible of these orders and by 1099 had founded a large hospital in Jerusalem to care for the sick, the injured and the dying — all the results of the Crusades. Today this order still plays a significant role in health care. A spin off in some parts of the world is the St. John Ambulance Corps. Other military orders were also instrumental in providing care and treatment for the sick, orders such as the Teutonic Knights and the Hospitallers of St. Lazarus. However, with the passage of time the Teutonic Knights faded into the books of history while the Hospitallers of St. Lazarus continue to this very day.⁴⁶

The second significant factor in health care during this time was the continuing growth of health care facilities themselves, especially hospitals. With that growth came the need for more rules and regulations. Inevitably, the canonical regulations exerted influence on the health care facilities associated with the Church at this time.⁴⁷

The third factor in the development of Catholic health care was the rise of the hospital guilds, “organized confraternities of laymen, usually living under a religious rule who dedicated themselves to the care of the sick.”⁴⁸ The establishment of these guilds gave impetus to the emergence of a new branch of law, hospital law. The hospital soon became regulated by the canon law of the period, especially in regards to the administration of ecclesiastical property, the appointment of hospital chaplains, and the rise of new religious communities.

Health care and the way it was delivered in the thirteenth century underwent drastic changes. The canon law of the period prohibited clerics and monks from practising medicine in an active way. Though care of the sick continued to be a work of charity, the actual practice of medical science was gradually transferred to the secular domain. Three main factors lead to this prohibition:

- the practice of medicine was widely perceived as a business;
- the motive behind the delivery of health care appeared to be greed rather than charity;
- certain moral issues and medical practices and procedures came into conflict with Church teaching;

- the ministry of healing came to be perceived as irrelevant and contrary to both monastic and clerical life at the time.⁴⁹

With the closing of the Middle Ages, the health care apostolate in the Church experienced a set back or period of demise. It would take some two hundred years, together with new and dynamic approaches, to instill new life into an age-old essential work of the Church.

4. Sixteenth and Seventeenth Centuries

Indeed, with the dawning of the sixteenth and seventeenth centuries, the health care apostolate in the Church experienced a renewed interest. New religious institutes, especially of women, included health care among their proper works. By doing this, a new dimension was given to this work of charity and mercy.⁵⁰ F. Cleary writes:

Religious women, however, were not drawn to the practice of medicine as physicians, but in response to a perceived lack of humane and Christian treatment of patients, especially the poor, neglected, and abandoned.⁵¹

Unlike in the late Middle Ages, the involvement of the Church was redirected to the care of the sick, to compassion, and to the manner of treating the ill. These were to be the overall essentials governing the health care facility in this new period.⁵² With the revival of religious life, a new age dawned in the way care was perceived and carried out.

The Sisters saw their ministry as worthy of formally Christian witness for two reasons. They brought a Christian presence to the experience of illness and disability in response to the example and command of the Lord they had vowed to serve. They also sought to treat all patients equally, regardless of social and economic status, and thus proclaimed God's universal salvific will and special love for the neglected and powerless.⁵³

Thus, this period ended on a note of optimism. The stage was being set for new discoveries in a new land and with this would come the revitalization of the Church's involvement in the health care apostolate. Central to this would be the founding of new religious institutes for the sole purpose of providing care and treatment to the sick, the injured and the dying. These integral works would now have an opportunity to flourish to great heights and the foundations were laid for a health care system which still exists to this very day.

II. DEVELOPMENT OF THE CATHOLIC HEALTH CARE APOSTOLATE IN CANADA

Health care and the Catholic Church in Canada have had a long association, going back to the very beginnings of the nation itself.⁵⁴ Braving the uncharted waters of the Atlantic, early adventurers and settlers etched out for themselves and their descendants a new world. Not long after reaching the shores of this New World, it became evident that some form of providing care for the sick and the injured was required, both for settlers and native peoples alike. Other factors soon came to the forefront in establishing facilities to treat the sick, factors such as the conversion of the native people to the faith, the care of the colonists and the injured soldiers, and the control of diseases such as smallpox and fever.⁵⁵

With the dawning of the seventeenth century came a new religious awakening. Great reformers like Theresa of Avila, Ignatius Loyola, Francis de Sales, Vincent de Paul, Camille de Lellis and countless others instilled new hope, new vigour and a promising future for the Church.⁵⁶ During this period, there existed a mood of excitement and enthusiasm concerning the discoveries being made in the New World. Those seeking to engage in heroic challenges and new possibilities for God and country hurried off to travel across the ocean. A new sense of optimism existed in the hearts and minds of these early adventurers – would it be possible to have a Catholic land on the other side of the Atlantic?⁵⁷

From its modest beginnings, the health care apostolate has planted deep roots and become ingrained in the very fabric of Canadian life. History has witnessed the expansion and flourishing of health care facilities, thus laying a solid foundation for the highly technical and complex system now experienced in health care delivery today. Historical accounts show that the earliest hospital facility in America was apparently founded in 1503 at Santo Domingo. A second such facility, Immaculate Conception Hospital in Mexico City was founded by Cortez in 1524.⁵⁸

The first step taken toward establishing any semblance of health care facilities in Canada goes back to the year 1625. Arriving at Quebec City, Jesuit missionaries embarked on a mission of evangelization of the

native peoples of the New World, especially the Hurons. By 1634 enough advancement had been achieved to allow Jean de Brébeuf and his companions to journey westward into what is now Ontario. In 1639 the small missionary band could establish the thriving mission station of Ste-Marie des Hurons (near present-day Midland, Ont). This quickly became the home base and centre of operations for further Jesuit missionary endeavours. At Ste-Marie, basic educational skills along with forms of social assistance were provided. Essential to these early mission stations was the school, where tenets of the faith could be transmitted. Evidence exists to attest that a facility providing care and treatment for the sick was attached to the school. The *Jesuit Relations* state that:

in 1640 the major buildings of the European type were begun. By 1642 the Church, dedicated to St. Joseph, and the hospital had been constructed outside the area built by the Father [...]. The hospital itself was 44 feet long and 40 feet wide with a small annex, 14 feet by 10, at one side [. . .] There was some evidence of a partition dividing it into two wards, 44 feet long, 20 feet wide, approximately [. . .].⁵⁹

Another major religious institute instrumental in the establishment of health care facilities during the early years of settlement was the Augustinian Sisters of the Mercy of Jesus. Arriving from Dieppe, France, on July 31, 1639, they settled at Quebec City and later in that same year founded the Hôtel-Dieu Hospital. This venerable institution went on to provide active treatment to the sick for nearly three hundred years, until in 1938, it was converted into a facility designed to house and care for the elderly.⁶⁰ Although dealt with later in this work, mention must be given to the prominent role in the health care apostolate in the early days of Canadian history exercised by the Religious Hospitallers of St. Joseph.

In 1737, the first religious institute founded by a Canadian born woman, Marguerite d'Youville,⁶¹ took the title of the Sisters of Charity, or as they became known, the "Grey Nuns." Their apostolate from the very outset was to live the spirit of the Gospel by caring for the sick, the poor and the dying. The various branches of the Grey Nuns have been instrumental in founding health care facilities elsewhere in Quebec and throughout Ontario and parts of Northern, Western and Eastern

Canada.⁶²

Shortly after the Grey Nuns were founded, the administration of the General Hospital of Montreal (founded by the Charon Brothers 50 years before) was entrusted to them. Like others before them, they were not to be exempted from countless hardships and difficulties in carrying out their apostolic work. Despite all the obstacles that faced them, whether fire, financial woes, even differences with government authorities, the “Grey Nuns” persisted and remained steadfast and faithful to their original apostolate of caring for the sick.⁶³

Throughout the country, various other religious institutes of women⁶⁴ responded to the countless requests from local and missionary bishops to establish health care facilities, ranging from hospitals, nursing homes and clinics, to orphanages. Despite enormous challenges and setbacks, these remarkable pioneers embarked wholeheartedly in carrying on this integral part of the Church’s mission. Their faith, their courage, their firm conviction in the dignity of the human person at all stages of life have made them giants in the shaping of the health care system now in place in Canada. They have for more than three hundred years laboured to ensure that the essential health care apostolate continues to be exercised in this time and place.

III. EVOLUTION OF CATHOLIC HEALTH CARE IN THE PROVINCE OF NEW BRUNSWICK

A. The Context

The Province of New Brunswick encompasses an area of some 73,497 sq. km. (28,354 sq. mi.) with a population of 738,133. Its heritage is indeed a diverse one: Micmacs, Maliseets, Loyalists, Acadians, Irish, Scots, Danes and German — each ethnic group contributing significantly to the development of the Province. The industrial base of the province lies in logging and forestry, mining, agriculture, fishing and trapping, manufacturing and tourism, while the areas of communications, advanced technology, energy, aquaculture, computer software, environmental engineering services and advanced forest products are gaining in popularity. New Brunswick continues to be Canada's only officially bilingual province with a 35% French speaking population. Religiously, 53% of the population are Roman Catholic, 40% Protestant, 1% practice other religions, while 5% practice no religion.⁶⁵

Before the arrival of European settlers in the early years of the seventeenth century, the methods and medicines used in the treatment of sickness and injury by the native peoples revolved around the medicine man and a variety of natural products such as teas, herbs, splints, etc. With the discovery and naming of the St. John River in 1604 by Samuel de Champlain came the introduction of rudimentary medical practices adopted from the continent and adapted somewhat to the new world situation.⁶⁶

At this time New Brunswick basically remained a land of trees with a sparse population. It was not until the 1780s and the influx of the United Empire Loyalists from the northern United States that the actual settlement of New Brunswick took place.⁶⁷ In 1784, by promulgation of Royal Charter, New Brunswick was officially created a province.⁶⁸ At the time, small rural settlements whose economic base revolved around farming, fishing and lumbering comprised most of the province. The principal ethnic groups populating the province were mostly native peoples (Micmac, Maliseet, and Algonquins), Acadians, and British settlers, later followed by the Scots and Irish. Though rural in makeup, population shifts did occur, thus allowing for the development of urban

centres like Saint John and Fredericton. However, with the shift in population also came increased problems, especially in terms of health matters, caused by the spread of communicable diseases. To help in the treatment and prevention of such epidemics, primitive means of health care were employed and public health at the time amounted basically to trying to meet any type of emergency that might arise.⁶⁹

By the late seventeenth century the province began experiencing an upsurge in the number of immigrants coming to settle, especially due to the possibilities being offered in the lumber industry. With immigration came also the rapid spread of such diseases as typhus, cholera and smallpox.⁷⁰ The port city of Saint John, known for its ice-free harbour, became the logical point of entry for thousands and as a result bore the brunt of these epidemics. Poor sanitation, combined with an inadequate public water supply system, further added to the rapid spread of infectious diseases, throughout the city and the province.

To control the spread of epidemics, the Legislative Assembly in 1796 promulgated the first Public Health Act.⁷¹ With this Act came the introduction of the quarantine facility, an entity which remained familiar in the province throughout much of the nineteenth century. However, the quarantine facility was not to be the answer to the prevention of disease in the province. In fact that which it was intended to prevent ended up being the main cause of the spread of these infectious diseases.⁷²

By 1833 the rampant spread of Asiatic cholera along with scarlet fever, diphtheria and smallpox throughout the province, forced the government to enact legislation thereby bringing into existence community health boards. These boards were mandated to do whatever was necessary to prevent the further spreading of disease. However, for the most part they achieved little if anything and the end result saw them falling into disuse.⁷³

By the mid-nineteenth century, the city of Saint John was a bustling sea port basking in a time of great prosperity. Shipbuilding and lumbering drew lucrative contracts to the area, resulting in population growth and increased wealth. However, the period also witnessed tremendous inadequacies in terms of proper sanitation and public water supply. These became a source for the spread of disease and sickness and which could not be treated due to the lack of health care facilities.⁷⁴

One event, etched in the minds and hearts of many, was the influx of immigrants from Ireland. By 1847 some 17,000 poor, uneducated and feeble Irish were forced to leave their native land because of the devastating potato famine. Two options were available at the time: face starvation and death, or, seek refuge elsewhere in the hopes of beginning anew. Countless numbers frantically bought passage in search of a new land, new freedom and security, and the possibility of a new life for themselves and their family. However, Saint John at this time was a Loyalist City, incorporated in 1783 by fleeing colonists loyal to the Crown. These became successful in business, politics and other areas. The Catholic population for the most part remained impoverished and uneducated.⁷⁵

In 1854, the most serious outbreak of cholera ever experienced in New Brunswick took place. The result of an infectious disease transmitted by bacteria in contaminated water supplies,⁷⁶ it spread rapidly, especially in the urban centres, causing hundreds of deaths in the City of Saint John alone. The cholera epidemic caused a realignment of the local health boards (in Saint John) as well as provoking calls for improvement in public sanitation and water supply systems.

Before New Brunswick's entry into Confederation in 1867, facilities designed specially for the treatment and care of the sick were nearly nonexistent. Almshouses doubled as a place of caring as well as providing some form of assistance to the poor, the destitute, the elderly, the crippled, the mentally handicapped and the indigent sick.⁷⁷ These primitive institutions left much to be desired and soon came under suspicion as the breeding grounds for the spread of diseases. In all reality, the almshouse provided a bandaid approach to the provision of care and attention to the sick.

The only facilities existing especially as hospitals in New Brunswick at pre-Confederation time were the military and marine hospitals.⁷⁸ These offered specialized health care to service personnel. With the continued threat of infectious diseases, new institutions besides the quarantine station had to be established, whether the 'fever house' in Saint John, or those on the Miramichi.⁷⁹ Another institution that gained in popularity around the same time in New Brunswick was the leper-colony, near Chatham. D. Arbuckle writes of this:

Leprosy is a disease which causes skin lesions, nerve paralysis and physical mutilation. Its spread in the northern counties of Gloucester and Northumberland led to the establishment of a lazaretto or house for diseased lepers, on Sheldrake Island in 1844. The mysterious disease was feared and misunderstood. The local Board of Health, revived to deal with the emergency, was convinced that the disease was caused by people heating their houses in the winter with closed stoves instead of fire-places, thus creating a tropical climate which bred infections. The sick often fled into the woods to avoid isolation under armed guards in the lazaretto. In 1849 the institution was moved to Tracadie.⁸⁰

Leprosy aided in bringing the Hospitallers to New Brunswick. By 1820, this dreaded disease had been detected in the northeastern section of the province, especially in Gloucester and Northumberland counties. In an attempt to control the disease, the provincial government established a facility whose sole purpose was to treat and prevent the spread of leprosy. The lazaretto,⁸¹ located on Sheldrake Island, could accommodate up to twenty patients and it was the only one in the whole of Canada. By 1849, due to dissatisfaction with the location, authorities arranged for its transfer down river to Tracadie. In 1868 Bishop James Rogers,⁸² the Bishop of Chatham, requested assistance from the Religious Hospitallers of Montreal.⁸³ The sisters responded positively to his request.

Catholic health care in New Brunswick owes its existence to the legacy of four religious institutes of women.⁸⁴ Their vision, faith, zeal and commitment laid the foundation for the 130-year tradition of providing care, concern and compassion to the sick, the orphan, the elderly, the suffering and the dying. The next section of this work will give an account of each individual religious institute and its contribution to health care in the province.

B. The Religious Institutes

1. Religious Hospitallers of Saint Joseph

The involvement of the Religious Hospitallers of Saint Joseph with Catholic health care in New Brunswick dates from 1868 and the arrival from Montreal of sisters assigned to administer the leper colony at Tracadie on the province's Acadian Peninsula. Theirs has been a legacy of faith and witness ever since in living out their vocation of providing care and compassion to the sick, the suffering and the dying. The Religious Hospitallers of Saint Joseph have certainly had a direct impact on health care delivery in New Brunswick for over a century and continue this work to this very day. In order to appreciate their contribution, an understanding of their history needs to be gained.

The year is 1630; the place, La Flèche in France and the centre of a dream. Jérôme Le Royer de la Dauversière, a resident of that city, dreamed of founding a religious institute of women for a threefold purpose: (1) to colonize and evangelize the New World, (2) to care for the sick, and, (3) to establish a hospital to treat and care for settlers and native peoples alike on the yet to be settled island of Montreal.⁸⁵ In 1636 a young Parisian priest, Father Jean Jacques Olier dreamed of founding a seminary in the New World to provide adequate and suitable priests for Montreal and surrounding areas.⁸⁶ These reported dreams of two individuals unbeknownst to each other would have a long-lasting impact, not only on the Island of Montreal but beyond. Another associate of La Dauversière, since 1634, Baron de Fancamp, also became involved in these dreams and the three set about planning the groundwork for three religious institutes for the New World – one to train priests, one to train hospitallers, and one to train teaching sisters.⁸⁷

In 1636, La Dauversière gathered a small group of women who came to form the beginnings of the religious institute under the heavenly patronage of Saint Joseph. Their apostolate would be the colonization and evangelization of the New World and the provision of care and treatment for the sick and the poor.⁸⁸ In the first Constitutions of the new order, Jérôme de la Dauversière wrote the following concerning the purpose of the Religious Hospitallers of Saint Joseph:

The Daughters of Saint Joseph will be persons entirely consecrated to God to serve Him fervently in the exercise of the

spiritual life and in the practice of perfect charity towards their neighbour, and especially dedicated to the service of Jesus Christ in the person of the poor who are His members.

The spirit of this family is that of a holy liberty of the children of God which makes the soul attentive to self, faithful to God, pure in her life, simple in her intentions, gentle in her conversation, cordially united with her sisters, tenderly charitable towards the sick poor, stable and unshaken in all circumstances and events of her life and desirous about all to be pleasing to God.⁸⁹

To help in making La Dauversière's dream become a reality, Jeanne Mance,⁹⁰ a laywoman of remarkable zeal and dedication accompanied Paul de Chomedey, Sieur de Maisonneuve and his companions, arriving and settling in Ville Marie in 1642. Her first concern and priority was the establishment of a small facility to provide care and treatment for the sick. Thus, she laid the foundation for what was to become a 350-year tradition of caring for the sick, the suffering and the dying on the Island of Montreal.

In 1653, Montreal witnessed the arrival of yet a second contingent of settlers from France. This group would also settle and colonize the island of Montreal. Among the group was a French lady from Troyes, named Marguerite Bourgeoys.⁹¹ She quickly became an avid supporter of Jeanne Mance and her apostolic work, providing great assistance, especially in times of need, in the health care apostolate.⁹² To this very day a close bond continues to exist between the Sisters of the Congregation of Notre-Dame and the Religious Hospitallers of Saint Joseph.

By 1654, the small facility at Montreal began to outgrow its usefulness. The need existed for a much newer and larger institution to carry on the work of providing care to the sick. An undertaking of such immense proportion would require substantial amounts of money and adequate personnel to administer and staff the new facility. Faced with yet another challenge, Mance, in 1658, travelled again to her native land in search of funds and labour.⁹³ She would not be disappointed. Finally her prayers and years of perseverance proved successful. In 1659, permission was granted for three members of the Religious Hospitallers to go to Montreal. On October 20, 1659, Mother Judith de Brésoles, Sister

Marie Maillet and Sister Catherine Mace⁹⁴ arrived at Montreal, “a city of only 160 men, fifty families, one hundred new colonists, and about fifty houses.”⁹⁵

The Religious Hospitallers were not without their share of trials and tribulations. They too encountered gruelling poverty, harsh winter conditions, even fear of death from Indian attacks. As if this were not enough, the sisters had to endure the forces of nature, especially the earthquake of February 5, 1663, and the fires of 1696, 1721 and 1735.⁹⁶ Despite all the hardships and difficulties inflicted upon them, they remained firm in their devotion and dedication to the health care apostolate.

By 1841, after nearly 182 years of service and enormous setbacks and undertakings, the Religious Hospitallers of Saint Joseph were ready to begin a new chapter in their distinguished history. They would expand their apostolate beyond the island of Montreal. The first convent to open outside Montreal was in Kingston, Ontario.

On July 16, 1869, again at the request of Bishop Rogers, Sister Louise D’Avignon, Sister Helen McGurty, Sister Beauchamp (Sr. St. Louis) and Sister Vitaline, came to Chatham, NB and opened the first Hôtel-Dieu Hospital in the rectory built by Father John Sweeney, who would succeed Bishop T.L. Connolly as Bishop of Saint John. Despite their share of difficulties and a fire in 1878, the Religious Hospitallers have continued to serve the sick throughout New Brunswick.⁹⁷ In 1949 a new challenge prompted the Religious Hospitallers to establish a facility to care for the needs of the elderly citizens of the Miramichi region of New Brunswick. As a result, St. Michael’s Academy, a girl’s boarding school, was renovated and became Mount Saint Joseph nursing home, with a new facility constructed in 1975.⁹⁸ The Religious Hospitallers also have health care facilities in other regions of the province, both hospitals and nursing homes. These include the Hôtel-Dieu in Perth-Andover,⁹⁹ Hôtel-Dieu in St. Quentin,¹⁰⁰ Hôpital de l’Enfant-Jésus in Caraquet,¹⁰¹ and two nursing homes, Foyer St. Joseph at St. Basile,¹⁰² and Foyer Notre-Dame de Lourdes at Bathurst.¹⁰³

2. Sisters of Charity of the Immaculate Conception of Saint John

In 1852, Thomas Louis Connolly¹⁰⁴ became the second bishop of Saint John, succeeding Bishop William Dollard. The saintly and much re-

spected churchman wasted no time in taking up the challenge that awaited him as chief pastor. His first concern was what to do with so many wretched individuals. Connolly travelled to New York City in a vain attempt to seek the assistance of the Sisters of Charity, known for their dedicated work of caring for the needy, the young, the sick and the uneducated. Mother Jerome, the superior of the Sisters, decided to visit Saint John to witness first hand the conditions of Bishop Connolly's cathedral city. Definitely moved by what she saw, on her return to New York she wrote the following:

I certainly did try to interest the Council by every statement I could think of to give Sisters to that mission, to have pity on the poor children there going to destruction, although candidly, I did not see who could be spared.¹⁰⁵

By 1854 the worst cholera epidemic in the history of the city broke out, claiming many victims and leaving countless numbers of orphans. This forced Bishop Connolly to make another urgent plea requesting the assistance of the Sisters of Charity in New York. Again Connolly received the disheartening news that the institute was still not able to send professed sisters to the area. However, a silver lining in what appeared to be a dark cloud of refusal and rejection shone forth. The Superior and her council gave Bishop Connolly their consent to approach the Order's novice members – perhaps some of them would be interested in his dilemma. Prayer and perseverance were rewarded and, in September 1854, a group of novices arrived at Saint John, thus beginning a new chapter in the history of Catholicism in New Brunswick.

From this small band of courageous and faith-filled young women, Bishop Connolly founded the Sisters of Charity of the Immaculate Conception of Saint John. The early members of the institute, namely, Honoria Conway (Mother M. Vincent),¹⁰⁶ Mary Routanne (Sr. M. Frances), Mary Madden (Sr. M. Joseph), and Annie McCabe (Sr. M. Stanislaus)¹⁰⁷ quickly set about caring for the needs of those mentioned in the first Constitution approved by Bishop Connolly.¹⁰⁸ Throughout the city, the sisters soon began establishing houses. From the events of the mid-nineteenth century combined with the vision of Thomas Connolly, the groundwork was being laid for further apostolic endeavours by the

Sisters of Charity.

The beginning of the twentieth century witnessed a steady growth in the membership of the small religious institute. As a result of this, the sisters were now able to expand their horizons and establish missions elsewhere in the Diocese of Saint John and even beyond the borders of New Brunswick. In response to an appeal to care for orphans in Western Canada the sisters journeyed to Saskatchewan. They soon endeared themselves to those whom they served and won the admiration and respect of the community of which they were part. By 1906 the Sisters of Charity, after a request was made to entrust the local hospital to their care, ventured out into another integral part of the Church's mission – the care of the sick. With the opening in 1910 of Holy Family Hospital in Prince Albert,¹⁰⁹ the long tradition of involvement in the health care apostolate by the Sisters of Charity of the Immaculate Conception was taking root.¹¹⁰ This would subsequently be followed by the opening of the Saint John Infirmary in 1914, later to become St. Joseph's Hospital. The hospital and the facility caring for the elderly were to form the nucleus of Catholic involvement in health care in the City of Saint John.¹¹¹

3. Les Soeurs de Notre- Dame de Sacré-Coeur

Les Soeurs Notre Dame du Sacré-Coeur were officially founded in 1924 when fifty-three Acadian members of the Sisters of Charity of the Immaculate Conception of Saint John broke away to live in a French community under basically the same rule as that intended in 1854 by Bishop Connolly. Previous attempts in 1871 and again in 1914 to establish a separate community failed to receive permission from the General Superior or the Sacred Congregation of Religious. However, in 1922/23, Sister Marie-Anne (Suzanne Cyr), an instrumental figure in the new institute, received a reply to yet another request. Mother Alphonse, then General Superior of the Sisters of Charity, suggested a complete break allowing for the creation of the new religious institute. Formal permission was granted on February 8, 1924, with the foundation taking place on February 17, 1924. It was also on this date that the first General Chapter was held and the election of a General Superior took place.

The newly established religious institute grew rapidly and quickly embraced the apostolates of education and health care. Membership in

the community reached 500 in the 1960s and witnessed expansion to Louisiana, Peru, Japan, Columbia, and Haiti as well as other Maritime centres. Today members of Les Soeurs de Notre-Dame du Sacré Coeur are found mainly in New Brunswick and Nova Scotia. They continue their foreign mission in Haiti.

Faithful to the invitation and challenge of Vatican II to re-assess and re-examine religious life at the end of the 20th century, the sisters expanded and adapted their apostolates to respond to the needs of those whom they serve. Despite all of this, Les Soeurs de Notre-Dame du Sacré-Coeur continue to exercise their original educational and health care apostolates.¹¹²

4. La Congrégation des Filles de Jésus

Les Filles de Jésus trace their origins to the Brittany region of France towards the end of the eighteenth century. The French Revolution marred this period in French history causing much hardship on the general populace. Many suffered from lack of basic health care and educational skills. The hardest hit were the poor residing in the rural areas of the country. Despite the hardships and difficulties encountered, the people remained steadfast and loyal to Catholicism. The Church responded to the needs of the people as best it could, at least on the parish level. Basic education and various other forms of social assistance were given in an attempt to alleviate the situation.

A local parish priest, Father Pierre Noury,¹¹³ conceived the idea of a religious institute of women, dedicated to apostolic work among the poor and needy. In 1834, Les Filles de Jésus began with only five women professing vows and dedicating themselves to lives of service.¹¹⁴ Under its first foundress, Perrine Samson,¹¹⁵ the institute flourished and engaged in education, the care of the sick, orphans and the elderly; it also offered assistance in whatever capacity the Sisters were needed. By 1884, Les Filles de Jésus grew to some five hundred members, spread out in more than 100 areas of Brittany. They soon won the admiration and respect of all those whom they served.

Les Filles de Jésus came to Canada in 1902, welcomed by bishops eager to have the sisters serve in various apostolates, but especially in education and health care. Religious houses soon opened in Alberta, Quebec, Nova Scotia and New Brunswick.¹¹⁶ Eager to share the life and spirit of

the Filles de Jésus, Canadian women soon joined the institute and with zeal committed themselves to lives of service.

Remaining faithful to the dreams of Father Noury and the mission entrusted them by their foundress, Perrine Samson, the Filles de Jésus number more than 2,000 members today and can also be found in Africa, the West Indies, Honduras, Columbia and Chile. Seven hundred members alone can be found in Canada.¹¹⁷ In an article on the charism of the institute in health care institutions it is stated:

From the very beginnings of our congregation, the Filles de Jésus were called to care for the sick and the poor. [...] This has been a tall order to fill and certainly the Sisters needed the support of everyone they were ministering to — the sick and the aged, yes, but also all people with whom they worked.

From the beginning the Sisters were conscious that their institutions were an extension of the Church. Catholic health institutions have arisen over the centuries in response to Jesus' call to heal and care compassionately for people. The Church's mission to proclaim the reign of God and to set people free from sickness, sin, evil and death is a direct mandate given by Jesus. (Mt. 10:8).¹¹⁸

C. Health Care in New Brunswick

Economic growth and prosperity marked the period following New Brunswick's entry into Confederation. The shipbuilding and lumbering industries witnessed unprecedented success. With this success came the long-awaited improvements to the health care delivered in the province. Instead of just providing basic and rudimentary health care, actual facilities in which the sick could be treated and cared for began gaining popularity.¹¹⁹

Much needed reform of the social welfare network in Canada was also being called for during this period. In New Brunswick, restructuring meant updating medical procedures and knowledge, upgrading equipment and enhancing sanitary conditions. The port city of Saint John, with the largest urban population would realize the most benefits due to reform

of the health system. It was in 1865 at Saint John that the first public hospital in the province opened its doors, thus paving the way for more hospital construction.¹²⁰

Post-Confederation New Brunswick was marked by yet another significant development in the provincial health care system: the professional nurse. Again the dedication and professionalism of the religious institutes assumed an instrumental role in this regard. Nursing schools, operated by the Religious Hospitallers of Saint Joseph, the Sisters of Charity and the Sisters of Providence produced some of the best nursing personnel in the province and have had a profound effect on the health care system to this very day.

Under the terms of the British North America Act in 1867¹²¹ health care was assigned to the jurisdiction of the provincial government. All facilities, their establishment and their administration came under provincial domain, though until the end of World War I, municipalities were the primary agents responsible for providing health care.¹²²

The Public Health Act of 1875 legislated in Britain influenced to a great extent New Brunswick's Public Health Act passed in 1887.¹²³ This Act provided for the creation of a Provincial Board of Health. Under this Board, health districts were established under a local Board of Health, with responsibilities ranging from conducting investigations and making recommendations regarding public sanitation to controlling contagious diseases. However, this system fell into disarray in many locales with the exception of the Saint John Board of Health. This Board continued to be instrumental in putting forth recommendations regarding health care reform. It was due to its influence that in 1918 the Department of Health was created as a separate portfolio of the provincial government.¹²⁴

Health care and how it was delivered became issues of vital importance, not only in New Brunswick, but also throughout the nation. The years immediately following World War I brought about calls from many sectors for social reform, chief of which was the reform of the public health system. With the creation of the health ministry in New Brunswick, a new Public Health Act was promulgated in 1918. This Act brought about the establishment of three health districts: Newcastle, Fredericton and Saint John. Each district came under the vigilance of a

District Medical Health Officer. In turn, these health districts were further divided into subdistricts, with special emphasis placed in the appointment of a medical inspector for schools. Between New Brunswick's entry into Confederation and the end of World War I, "public health in New Brunswick evolved from a decentralized, poorly administered, inefficient system into a centralized provincial Department of Health. A new era in the province's health care system was launched with the creation of this department."¹²⁵

The years following the end of World War I could be described as the beginning of the so-called welfare state. The disruption in social services caused by the war, combined with the effects of the Great Depression, led to new demands for reform. Health care would be no exception. This period could even be described as the "boom years" for health care facilities in New Brunswick.¹²⁶

Escalating costs in the delivery of quality health care was leading to greater federal government intervention in what was a provincial jurisdiction. In this particular period, the stage was being set for discussions regarding the feasibility of a "comprehensive and universal health insurance program."¹²⁷ Prevention was the key word in this period and immunization programs for school children, hygiene, and school inspections were introduced. By the 1930s the position of the public health nurse became an essential part of the health care system in the province, with duties ranging from infant care to tuberculosis follow up.

Marked improvement in sanitation, public water supplies and the establishment of dental clinics dominated the period following the war. A reorganization of provincial health districts also took place at this time. Five health districts were to be created coming under the authority of a District Medical Health Officer. Further reorganization in the Department of Health was now leading to more government involvement in health care delivery. For example, the public health nurse no longer came under the authority of the local Board of Health, but under the provincial Department of Health. This meant medical inspection of schools was also placed under the Department's jurisdiction.

By the 1940s new concerns began to emerge especially regarding the rising number of polio victims in the province. As a result, rehabilitation programs, free vaccination programs and government take over of

tuberculosis hospitals were initiated by the provincial Department of Health. With the introduction of the National Health Grants in 1948 by the federal government, further expansion of provincial health care facilities, especially hospitals, soon became a reality in New Brunswick.

By 1949 New Brunswick had 49 hospitals, including several tuberculosis facilities, scattered throughout the province. The major problem was that most hospitals had developed to meet the needs of specific communities, resulting in a lack of cooperation and coordination between the institutions. There was also a lack of proper standardization, and since many of the hospitals only had a small number of beds, the overall system was inefficient.¹²⁸

The Depression years caused much havoc and uncertainty in all areas of life, including health care delivery. In an attempt to stimulate confidence and growth, the federal government proposed, among other things, the creation of a national health insurance program.¹²⁹ The proposal met with considerable opposition, especially in political circles and resulted in a Supreme Court decision in 1945 ruling the proposal unconstitutional. The Court reiterated that health care came under the jurisdiction of provincial governments and that the federal government was going beyond its competency as outlined in the BNA Act of 1867.

What resulted was the creation of the famous *Rowell-Sirois Commission on Dominion-Provincial Relations*, the introduction of the National Health Grants, and a system of equalization payments by the federal government to its provincial counterparts to offset the rising costs of providing quality health care. These payments helped “to transfer wealth throughout the country, with the aim of establishing a minimum level of basic service to Canadians. The federal health grant provided money for hospital construction, training of more personnel, and improvements in public health services.”¹³⁰

The National Health Grants of 1948 brought about increased activity in the delivery of quality health care in New Brunswick. Another significant factor in the system was the adoption in 1959 of a federal-provincial cost-sharing agreement for hospital insurance. First introduced in 1956, the agreement led to the implementation in 1971 of the national and

universal Medicare program. This program was to have immense repercussions on the way health care would be delivered throughout the country.¹³¹

The centennial year of Confederation, 1967, brought forth another massive change in New Brunswick. Then Liberal Premier Louis J. Robichaud introduced his plan for “Equal Opportunity.”¹³² The introduction of the Equal Opportunity program, the adoption of Medicare and the financial commitment by the federal government in the form of equalization payments, created an extensive and complex system of health care in the province. By the 1970s and 1980s, the economic recession and government restraints, the continuation of high costs and at times, inefficient health care delivery, were creating cracks in the system.

The federal government through the National Health Grants of 1948 put in place the necessary financial resources for the continued construction of health care facilities, especially hospitals, in New Brunswick. It was during the years 1948 to 1965 that existing Catholic health care facilities in the province were greatly improved and expanded and new facilities built.

In 1951, the provincial Department of Health conducted a survey proposing the regionalization of the health care system by dividing the province into a series of regions. Five health regions were proposed, with a large regional hospital, surrounded by satellite hospitals and clinics. The proposal remained just that. It never got off the ground. However, some forty years later this scheme, with modifications, would be adopted by the provincial government. So the groundwork for reform of the health care system in New Brunswick was being prepared as early as the 1950s.

Another further study was conducted in 1970 regarding the existing health care facilities in the province. This became known as the *Llewelyn-Davis Report* and proved very critical of what was occurring in the New Brunswick health care system.¹³³ Changes were also occurring in the Medicare program. By 1977 federal government contributions made to the province were reduced. As a result the provincial government implemented hospital user fees; however, these were short-lived due to massive protests in every sector of the province.

By the close of the 1970s it was becoming apparent that changes were needed and the health care system in New Brunswick overhauled. In 1978, yet another proposal was on the table. This plan proposed six regions with hospitals being divided into regional, district and community facilities. Through all these happenings one thing remains obvious: health care facilities, especially hospitals, gradually evolved from single independent facilities into a complex network of integrated services.¹³⁴

During the 1980s another proposal regarding the revamping of the health care system in the province was presented to government and other interested parties. However, it was not until the early 1990s that drastic changes actually occurred in the health care system, changes that would affect the mission of the Catholic Church in providing care to the sick. Despite some negative aspects such as the depersonalization of treatment, health care in New Brunswick has seen many advances in 200 years of history. Initially, the system was very haphazard with no scientific standards. Some patients received proper treatment, while others did not. Due to increased interest in public health resulting from advances in knowledge and more financial input by the federal and provincial governments, health care in New Brunswick has evolved into a universal public system in which all individuals have equal access to care.¹³⁵

CONCLUSION

This work has examined the long association of the Catholic Church in the health care apostolate. From its very beginnings, the Church has aligned itself with sick and suffering humanity. By establishing health care facilities, the various religious institutes especially have put a real and tangible face on the command of Christ to heal the sick.

More specifically, we have examined the presence and foundation of health care facilities in Canada and the Province of New Brunswick. Despite challenges and difficulties of one kind or another, the religious institutes down through the years continued to offer care, compassion and quality health care to those seeking their assistance. They have played a vital role in making health care effective and efficient. They have actualized the gospel and made health care an integral part of their apostolic mission. Without their significant contribution and determination, New Brunswick, indeed Canada itself, would be the poorer in terms of quality health care facilities.

ENDNOTES

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8. F. CLEARY, “The Church in Health Care,” p. 39.
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12. DEUTERONOMY 30:20.
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15. EZEKIEL 47.
16. ISAIAH 53:5.
17. CCCB, *New Hope in Christ*, p. 9.
18. L. DUFOUR, *The Dictionary of Biblical Theology*, (rev. ed.), New York, The Seabury Press, 1977, p. 544.
19. LUKE 13:16.
20. MATTHEW 11:5.
21. DUFOUR, *The Dictionary of Biblical Theology*, p. 544. The A. points out that “what is needed to bring about this healing encounter is faith, that is the essential and most important disposition required. It is faith in Jesus, faith in the kingdom he preached that would restore health and life. Without that faith, healing would not be a possibility.”
22. Ibid.
23. Ibid. p. 254.

24. MATTHEW 10:1.
25. MATTHEW 16:17.
26. ACTS 3:1; 8:7; 9:32; 14:8; 28:8.
27. 1 CORINTHIANS 12:9 ; 28:30.
28. CLEARY, "The Church in Health Care," pp. 38-39.
29. Ibid., p.39.
30. Ibid.
31. CCCB, *New Hope in Christ*, p. 13.
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33. Ibid.
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35. E. NASALLI-ROCCA, "History of Hospitals: The Christian Hospital to 1500," in *New Catholic Encyclopedia*, New York, McGraw-Hill Book Co., 1967, vol. 7, p. 159.
36. F. MOURRET, *A History of the Catholic Church*, (trans. by N. THOMPSON), St. Louis, MO, Herder Book, 1930, vol. 2, p. 474.
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39. J. CASEY, *Food for the Journey: Theological Foundations of the Catholic Health Care Ministry*, St. Louis, MO, The Catholic Health Association of the United States, 1991, p. 34.
40. NASALLI-ROCCA, "History of Hospitals: The Christian Hospital to 1500," p.159. This article goes on to state: "Reflecting his actions and the approval of the Council of Nicaea (325), Canon 75 of the pseudo-apostolic *Canones Arabici Nicaeni* declared that in every city separate facilities were to be provided for pilgrims, the sick, and the poor."
41. CCCB, *New Hope in Christ*, p. 14.
42. T. FRY et al. (eds.), *RB 1980: The Rule of St. Benedict in Latin and English*, Collegeville, MN, Liturgical Press, 1981, p. 183 (RB 4:16); p. 229 (RB 31:9); p. 235 (RB 36:1-10).
43. MOURRET, *A History of the Catholic Church*, vol. 3, p. 385, The Council of Aachen (Aix-la-Chapelle), held in 816, decreed that a hospital be founded beside each monastery and that it be placed in the charge of a man «to whom avarice is hateful and hospitality cherished, a man capable of giving to the poor all the care and relief that they need.»

44. CLEARY, "The Church in Health Care," p. 39.
45. H. BECK et al., *Handbook of Church History: From the High Middle Ages to the Eve of the Reformation*, (trans. by A. BIGGS), New York, Herder and Herder, 1970, vol. 4, pp. 183-187.
46. Members of the Hospitallers of St. Lazarus remain active in New Brunswick to this day.
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48. BECK et al., *Handbook of Church History*, vol. 4, p. 184.
49. F. CLEARY, "The Church in Health Care," p. 39. See also C. BACHOFEN, *A Commentary on the New Code of Canon Law*, St. Louis, MO, Herder, 1925-36, note 53, cfr. C.19, x,v,12.
50. Ibid.
51. Ibid.
52. Ibid., p. 40.
53. Ibid.
54. A. ANDERSON, *A New Vision, New Reality, New Structures in Congregationally Sponsored Health Care Ministry*, PhD dissertation, Toronto, University of Toronto Press, 1990, p. 1.
55. DOYLE, *Catholic Hospitals*, provides a detailed historical account of the development of the Catholic health care institutions . See especially pp. 41- 120. Also A. ANDERSON gives a brief historical profile of the beginnings of Catholic health care on pp. 1-5. S. MAILLET, "Development of Hospital Care in Canada," in *CHAC Review*, 17 (1989) 1, pp. 9-17 traces the historical development of the Catholic hospital in reference to the Religious Hospitallers of Saint Joseph.
56. Ibid., p. 46.
57. Ibid.
58. A. MCPADDEN, "History of Hospitals: 1500 to the Present," in *New Catholic Encyclopedia*, New York, McGraw-Hill Book Co., 1967, vol. 7, p. 165.
59. R. THWAITES, *The Jesuit Relations and Allied Documents*, Cleveland, The Burrows Bros. Co., 1897, vol. 26, pp. 201-2, Relations of 1643-1644. Cf. J. WILFRID, *Sainte-Marie Among the Hurons*, Toronto, Oxford University Press, 1954, pp. 103-104.
60. F. ROUSSEAU, *La croix et le scalpel: histoire des Augustines et de l'Hôtel-Dieu de Québec, 1639-1989*, Sillery, Editions du Septentrion, 1989, pp. 7-84.

61. Marie Marguerite Lajemmerais was born October 15, 1701 at Varennes, Quebec, twenty miles from Montreal; widow of François Madelin d'Youville, mother of six children, and foundress of religious women who would become officially known as the Grey Sisters of Charity of Montreal. She died on December 23, 1771 at Montreal; beatified May 3, 1959 by Pope John XXIII, with the title "Mother of Universal Charity"; canonized December 19, 1990 by Pope John Paul II. For more information on Marguerite d'Youville, see R. MCGUIRE, *Marguerite d'Youville: A Pioneer for Our Times: A Biography Based on the Life and Times of Marguerite d'Youville, Foundress of the Sisters of Charity (Grey Nuns) of Montreal*, Ottawa, ON, Novalis, 1982, 309 p.
62. MAILLET, "The Development of Hospital Care in Canada," p. 10.
63. SOEURS GRISES DE MONTREAL, *Recueil de Règles et Constitutions à l'usage des filles séculières administratives de l'Hôpital général de Montréal, dites les Soeurs de la Charité / recueil sur les anciens titres et usages de la Communauté; divisé en trois parties à Montréal, 1781*, [Montréal ? Soeurs grises, 19 -], 131 f. GREY NUNS OF MONTREAL, *Constitutions and Statutes: The Institute of the Sisters of Charity of Montreal, "Grey Nuns,"* General Chapter, 1981, [Montréal ?, Grey Nuns, 1982 ?], pp. 17-19.
64. Other religious institutes of women instrumental in the health care apostolate in Canada include: Sisters of Providence, Sisters of St. Ann, Sisters of St. Joseph, Sisters of Mercy, and so forth.
65. PROVINCE OF NEW BRUNSWICK, *New Brunswick at the Dawn of A New Century: A Discussion Paper on Demographic Issues Affecting New Brunswick*, Fredericton, NB, April 1996. Also see New Brunswick Department of Statistics - Census 1991 and 1996.
66. W. STEWART, *Medicine in New Brunswick*, Moncton, NB, Moncton Publishing Company, 1974, pp. 1-3, 21-27.
67. Saint John, NB, became Canada's first incorporated city on May 18, 1783.
68. S.N.B., 31 Geo. III, 1784, c. 31. See also, J. CARELESS, *Canada: A Story of Challenge*, (rev. and enl. ed.), New York, St. Martin's Press, 1964, p. 112.
69. J. HEGARTY, *Four Centuries of Medical History in Canada*, Toronto, MacMillan, 1928, vol. 2, p. 362.
70. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick: 1784-1984*, (= *Health Care in New Brunswick*), prepared by the Bi-Centennial Fredericton Historical Research Project, Fredericton, NB, 1984, p. 3.

71. Ibid., on p. 3 it is stated that The Public Health Act of 1796 “referred to the outbreak of smallpox in New England from 1788-1792, and was designed to impose Maritime quarantine to prevent the introduction of this disease. Maritime quarantine meant that all passengers on ships arriving in the port would be inspected to determine if any were carrying epidemic diseases. To prevent the spread of these diseases, the sick were to be kept isolated in quarantine stations. By 1799 this legislation had been extended to include all the province.”
72. Ibid., states on p. 3, “People then did not understand that typhus was transmitted by infected body lice. Consequently, they did not appreciate that putting the sick into filthy, overcrowded quarantine houses caused the disease to flourish.”
73. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 3.
74. ST. JOSEPH’S HOSPITAL, *75 Years of Caring: St. Joseph’s Hospital Souvenir Booklet*, Saint John, NB, St. Joseph’s Hospital, 1987, p. 1.
75. W. SPRAY, “Immigrants and Fever in New Brunswick in 1847,” in T. POWER (ed.), *The Irish in Atlantic Canada: 1780-1900*, Fredericton, New Ireland Press, 1991, pp. 107-126.
76. DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 4.
77. J. WHALEN, “Social Welfare in New Brunswick, 1784-1900,” in *Acadiensis*, 2 (1972), p. 172.
78. STEWART, *Medicine in New Brunswick*, p.83. Several other marine hospitals were established throughout the province in the colonial period, including ones at Saint Andrew’s (1825), Dalhousie (1844), Richibucto (1849), Buctouche and Bathurst.
79. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 4.
80. D. ARBUCKLE, *The Northwest Miramichi: A History of the Locality*, Ottawa, ON, Westboro Printers, 1978, p. 149. See also A. BERNARD, *Les Hospitalières de Saint-Joseph et leur oeuvre en Acadie*, Vallée-Lourdes, NB, Hospitalières de St. Joseph, 1958, pp. 65-66; M. LOSIER, *Children of Lazarus: The Story of the Lazaretto at Tracadie*, Fredericton, NB, Goose Lane, 1984, 176 p. Also, cf. S.N.B., 13 Victoria, 1850, c. 18, *An Act to Prevent the Spread of a Disorder Now Existing in Certain Parts of the Counties of Gloucester and Northumberland*; See also DOYLE, *Catholic Hospitals*, p.105, note 27.
81. *Encyclopedia Americana*, International ed., New York, Americana Corp., 1965, vol. 17, on p. 133 describes a lazaretto as being “a name once given

in various parts of the world to designate hospitals for the isolation and treatment of contagious diseases, especially leprosy. The word derived from the name of the Biblical character Lazarus, who in the Middle Ages was thought to be leprous because the Gospel of Luke describes him as ‘full of sores.’ In Mediterranean Sea ports, lazarettos were special buildings used to quarantine crews and passengers of ships from places where contagious diseases were known to prevail.”

82. Bishop James Rogers, First Bishop of Chatham, NB was born on July 11, 1826 at Mt. Charles, County Donegal, Ireland. He was ordained a priest at Halifax, Nova Scotia on July 2, 1851 and consecrated as the first Bishop of the Diocese of Chatham on May 8, 1860. Bishop Rogers died at the Hotel-Dieu Hospital at Chatham in 1903.
83. F. LAJAT, *Le Lazaret de Tracadie et la communauté des Religieuses Hospitalières de Saint-Joseph*, Montréal, Action paroissiale, 1938, p. 434. This book gives an excellent overview of the leper colony located at Tracadie, NB.
84. Sisters of Charity of the Immaculate Conception, 1854; Religious Hospitallers of Saint Joseph, 1868; La Congrégation des Filles de Jésus, 1903 and Les Soeurs de Notre-Dame du Sacré-Coeur, 1922. All four religious institutes have engaged in the health care apostolate which up to 1992, the date of the reorganization of health care services, consisted of seven hospitals, four nursing homes and one hospice. The Sisters of Providence of Montreal founded a hospital in Moncton, NB, in 1922 - Hotel-Dieu de l'Assomption. Ownership of this facility was transferred in 1967 to the provincial government. A new hospital replaced it, now known as the Dr. Georges L. Dumont Hospital.
85. DOYLE, *Catholic Hospitals*, p. 62. See also M. MONDOUX, *L'Hôtel-Dieu premier hôpital de Montréal d'après les annales manuscrites, les documents originaux de l'Institut des Religieuses Hospitalières de Saint-Joseph et autres sources, 1642-1763*, Montréal, Thérien Frères Ltée, 1942, pp. 34, 49, 51.
86. Ibid.
87. Ibid.
88. J. DESLAURIERS, *Like a Bay Tree: The History of St. Joseph Province*, Kingston, ON, Religious Hospitallers of St. Joseph, 1984, p. 2. Cf. MONDOUX, p. 57. DOYLE, in *The Catholic Hospitals of Canada*, on p. 63 writes, “The Religious Hospitallers of St. Joseph received the final decree of erection of the institute from the Bishop of Angers in 1643, and civil recognition in 1639, but it was only on January 8, 1666, that it was recognized as a Religious Institute by the brief of Pope Alexander III.”

DOYLE in note 26, p. 63 continues by stating that: “the fact that the sisters had only simple vows, contrary to the custom of the time, caused Bishop Laval to hesitate in granting them approbation. So even as late as 1670 he was to write to the Sacred Congregation for the Propagation of the Faith: Verum, in hujusmodi Constitutionibus et regulis, iam multa extra ordinaria et parum usitata in Ecclesia Dei pro feminis praefertum mihi visa sunt, ut dubitarem diu an expediret eas a me approbare, praesertim cum se ut religiosas approbare intenderent, et si in hujusmodi Constitutionibus, nulla nisi votum simplicium natura appareat, nec vestibus ulla ratione ab saeculari distinctus [...]” (Archives S. Cong. Prop. Fide, America Antille, vol. I, 1634-1760, p. 282).

89. In the revised Constitutions of 1991, RELIGIOUS HOSPITALLERS OF SAINT JOSEPH, *Constitutions and Rules of the Religious Hospitallers of Saint Joseph*, Montreal, Religious Hospitallers of Saint Joseph, 1991, pp. 17-22, it is stated: “The Religious Hospitallers of Saint Joseph live the liberty of the children of God as women of faith, incarnating Christ’s tender compassion in serving His members, especially the poor, the sick and the most needy, in union of charity.” Furthermore, the Mission Statement of the Religious Hospitallers of Saint Joseph states: “Faithful to its mission, the Congregation continues to announce the Good News of Jesus Christ by service to the poor, the sick and by education. The sisters participate in this mission by the quality of their being and service, revealing Christ’s compassionate love wherever they are missioned by their superior.”
90. J. MANCE: born at Langres, France on November 12, 1606. On May 9, 1641 she embarked with 12 others for Montreal, arriving on August 8 that same year at Quebec City. She died at Montreal on June 18, 1673. For more in depth information on the life of Jeanne Mance, consult F. DERROY-PINEAU, *Jeanne Mance: de Langres à Montréal, la passion de soigner*, Montréal, Bellarmin, 1995, 167 p. See also J. BERNIER, *L’Hôpital de Jeanne-Mance à Ville-Marie: son évolution à travers les siècles*, Montréal, Thérien Frères Limitée, 1958, pp. 25-26.
91. Marguerite Bourgeoys was born in Troyes, France, the capital of the province of Champagne on April 17, 1620. On June 15, 1653 she set out from the port of Saint-Nazaire, France, arriving on September 22, 1653 at Quebec City, and finally at Montreal on November 16, 1653. “On May 20, 1669 a written authorization to teach was given to the Daughters of Mother Bourgeoys by Bishop de Laval, but it was not until 1676 that, by an episcopal mandate, he officially approved the erection of the Congrégation-de-Notre-Dame of Montreal as a Community, in the ‘state of secular women,’ that is to say, non-cloistered.” See S. POISSANT,

Marguerite Bourgeoys: 1620-1700, trans. by F. KIRWAN, (2nd ed.), Montreal, Bellarmin, 1993, p. 39. Marguerite Bourgeoys died at Montreal on January 12, 1700. The cause of her beatification was introduced on December 10, 1878, by Pope Leo XIII, and the heroicity of her virtues was proclaimed by Pius X in a decree of June 19, 1910. She was declared Blessed on November 12, 1950, and on October 31, 1982 was canonized a saint by Pope John Paul II.

92. DESLAURIERS, *Like a Bay Tree*, p. 2.

93. *Ibid.*

94. BERNIER, *L'Hôpital de Jeanne-Mance*, pp. 35-36.

95. DESLAURIERS, *Like a Bay Tree*, p. 3.

96. MAILLET, "The Development of Hospital Care in Canada," p. 10.

97. CHAC, *Directory 1991-1992*, Ottawa, ON, CHAC, 1991, states on p. 106 that: "Hôtel-Dieu Hospital was founded in 1869 under the ownership and management of the Religious Hospitallers of Saint Joseph. It is a fully accredited, 125 bed general hospital. The inpatient care services are divided into medicine, surgery, obstetrics and paediatrics. Community health centers, each visited by approximately 16,000 patients, are in the small communities of Baie-Ste-Anne and Neguac. These are administered and staffed by Hôtel-Dieu. The nursing services at the Atlantic Institution (prison) in Renous are also staffed by Hôtel-Dieu." On April 1, 1992, administration of Hôtel Dieu Hospital was involuntarily transferred to the Region 7 Hospital Corporation in a government overhaul of health care in the province. In December 1996, the new Region 7 Hospital, located in the newly-formed city of Miramichi opened its doors, thus ending the Religious Hospitallers' apostolate in active treatment health care in the Chatham hospital.

98. *Ibid.*, on p. 111 describes Mount Saint Joseph as follows: "The Religious Hospitallers of Saint Joseph opened this facility in 1950 as a hospital for convalescent and chronically ill patients. Originally constructed in 1902 as a girls boarding school, the present facility opened in 1975. Special services include physiotherapy, occupational therapy, speech therapy, vision care, nursing care, social activities, and a Sister visitor program." This facility is still owned and administered by the Religious Hospitallers of Saint Joseph.

99. *Ibid.*, p.108 states that this facility first opened its doors in 1947. Owned by the Religious Hospitallers of Saint Joseph, a new building opened in July 1954, with 45 beds, an operating room, laboratory and x-ray department. Further additions and improvements were made in 1959, 1967 and 1978. The hospital was directed by a 13 member Board of Trustees.

On April 1, 1992, administration of this facility was involuntarily transferred to the Region 3 Hospital Corporation.

100. *Ibid.*, p. 109 states that the Hôtel-Dieu in St. Quentin opened in 1947 with 12 beds. In 1963, a new 40 bed hospital was built, offering the following services: general medicine, obstetrics, paediatrics and an outpatient department. In 1979, because of budget restraints, the Department of Health closed down 8 beds. On April 1, 1992, administration of this facility was involuntarily transferred to the Region 4 Hospital Corporation.
101. *Ibid.*, p. 106 states that this facility was founded in 1963 and owned by the Religious Hospitallers of Saint Joseph. Hôpital de l'Enfant-Jésus is an active care hospital with 64 beds. Services offered include acute care, emergency and outpatient departments. On April 1, 1992, administration of this facility was involuntarily transferred to the Region 6 Hospital Corporation.
102. *Ibid.*, p. 112 describes Foyer St. Joseph as a 126 bed nursing home owned by the Religious Hospitallers of St. Joseph. The facility serves the elderly and patients with physical and mental disabilities. Offering holistic care, the mission of the facility is to make the patients' lives as comfortable as possible in accordance with their culture, values, traditions and beliefs. It has been serving the community and surrounding areas since March, 1976.
103. CHAC, *Directory*, p. 111 states that Foyer Notre-Dame de Lourdes owned by the Religious Hospitallers of Saint Joseph was founded in 1932 as a hospital for T.B. patients. In 1972, its whole mission changed. With major renovations, the facility was converted to a home for the aged. It also accepts young disabled persons.
104. Thomas Louis Connolly, O.F.M. Cap., Born in Ireland, 1815, appointed Bishop of Saint John in 1852, consecrated in St. Mary's Cathedral at Halifax, NS on August 15, 1852 and arrived at Saint John on September 11, 1852. He was appointed archbishop of Halifax on April 15, 1859. Bishop Connolly was one of the Fathers of Vatican Council I. He died at Halifax in July 1876.
105. ST. JOSEPH'S HOSPITAL, *75 Years of Caring*, p. 1.
106. For a more detailed account on the life of Honoria Conway, see G. HENNESSEY, *Honoria Conway: Woman of Promise, Foundress of the Sisters of Charity of the Immaculate Conception*, Saint John, NB, 1985, p. 142.
107. E. LEGERE, *Laus Deo: 1854-1954: Centenary of the Sisters of Charity of the Immaculate Conception*, Saint John, NB, Raphaelite Press, 1955

(?), p. 14.

108. SISTERS OF CHARITY OF THE IMMACULATE CONCEPTION, SAINT JOHN, NB, *Rules for the Sisters of Charity of the Immaculate Conception*, Saint John, New Brunswick, 1854, 1st leaf : “They must be in an especial manner devoted to the care of the orphan, the instruction of the poor, and the attendance of the sick, even at the sacrifice of life itself.” Cf. SISTERS OF CHARITY OF THE IMMACULATE CONCEPTION, Saint John, NB, *Constitutions of the Sisters of Charity of the Immaculate Conception*, Saint John, NB [Sisters of Charity of the Immaculate Conception], 1983, on p. 13, “As Sisters of Charity of the Immaculate Conception, an apostolic religious institute of pontifical right founded in 1854, we are called to be with Christ and we are sent to serve the needs of his Church. By means of a variety of ministries which traditionally include the apostolates of Christian education, health care, and social services, we adapt to the needs of time and place in a spirit of faith, charity, simplicity and availability. In this way, we strive to be true to the charism of our Foundress, Honoria Conway and to the spirit of our ecclesiastical sponsor, Thomas Louis Connolly.”
109. Holy Family Hospital closed officially on September 30, 1997 bringing to an end 86 years of involvement in the health care apostolate by the Sisters of Charity in that western city.
110. ST. JOSEPH’S HOSPITAL, *75 Years of Caring*, p. 1.
111. CHAC, *Directory*, on p. 109 states that St. Joseph’s Hospital, Saint John, NB, was “founded in 1914 and owned by the Sisters of Charity of the Immaculate Conception. Services at the 123 bed facility include anaesthesia, internal medicine, orthopaedics, ophthalmology, otolaryngology, radiology, urology, family medicine, general surgery, pathology, and outpatient/emergency departments. Also the facility has a day care surgery unit and a diagnostic hostel. St. Joseph’s is associated with Dalhousie University Medical School and also provides experience for nursing and nursing assistant students from the Saint John School of Nursing.” On April 1, 1992, the administration of this facility was involuntarily transferred to the Region 2 Hospital Corporation. The directory on p. 112 describes the Rocmaura Nursing Home in Saint John, NB, as “a 150 bed nursing home owned by the Sisters of Charity of the Immaculate Conception and operated by the sisters and lay staff.” The Sisters began caring for the aged in 1888 at the old Mater Misericordiae Home on Sydney St., built by the Diocese of Saint John. In 1958 residents of the home relocated to the former orphanage on Waterloo St. Outgrowing its space, the Sisters made plans to construct a new facility and on December 16, 1972, Rocmaura opened to serve the

- elderly in need of nursing care. Basic Christian values dictate the spirit of the home so that the dignity and individuality of each resident is respected. The home strives to bring health and healing in an atmosphere which respects and affirms the sacredness of human life.”
112. CHAC, *Directory*, on p. 108 describes L’Hôpital Stella-Maris-de-Kent at Ste-Anne-de-Kent as follows: “Founded in 1964 and owned by the Religieuses de Notre-Dame du Sacré-Coeur. The facility serves a rural area, in the Northeast section of New Brunswick whose population is mainly Roman Catholic and French speaking. The facility provides basic health care services and has 45 beds.” On April 1, 1992, administration of this facility was involuntarily transferred to Region 1 Hospital Corporation.
 113. A. TROTTIER and J. FOURNIER, *Les Filles de Jésus en Amérique*, Charlesbourg, Impr. Le Renouveau Inc., 1986, p. 17.
 114. In the Constitution of Les Filles de Jésus of 1834 the following is found: “The goal set forth for the Congregation is to honor the Humanity of the Son of God by imitating His virtues, especially the virtue of charity and to take care of the sick and the aged.”
 115. TROTTIER and FOURNIER, *Les Filles de Jésus en Amérique*, pp. 19-21.
 116. CHAC, *Directory*, on p. 107 describes L’Hôpital St. Joseph de Dalhousie, Dalhousie, NB, as “an active treatment hospital founded in 1948 by the Religious Hospitallers of Saint Joseph and now owned by Les Filles de Jésus, it serves the needs of people residing in East Restigouche County in Northern New Brunswick. Services include: medicine, surgery, pediatrics, emergency department, pastoral care, diagnostic and therapeutic departments as well as outpatient services.” On April 1, 1992, administration of this facility was transferred involuntarily to the Region 5 Hospital Corporation.
 117. TROTTIER and FOURNIER, *Les Filles de Jésus en Amérique*, p. 4.
 118. E. BOUDREAU, “The Charism of the Congregation in our Health Care Institutions,” pp. 3.1-3.2. This was from a paper given at Moncton, NB, by Sister Boudreau on April 4, 1982 to a meeting of the Administrative Staffs of the hospitals and homes of Les Filles de Jésus.
 119. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 6.
 120. *Ibid.*, continues on p. 6 by stating: “Between 1867 and 1900 six other general hospitals opened in Chatham (1869), St. Basile (1873), Fredericton (1888), Moncton (1895), Campbellton and Tracadie. The Salvation Army Evangeline Maternity Hospital opened in Saint John in 1889. Between 1900 and 1914 four more hospitals were opened at St. Stephen, Woodstock, Grand Falls and Bathurst. Two tuberculosis hospi-

- tals also opened during this period near Moncton (1913) and in Saint John (1915). In addition, separate and specialized institutions still existed such as marine, military and mental health hospitals.”
121. *Ibid.*, on p. 7 states that: “Under the 1867 British North America Act, the provision of health care service was acknowledged as primarily a provincial responsibility. The federal government was given control of quarantine and of the establishment and maintenance of marine hospitals, while the provinces were given control of the establishment, maintenance, and management of hospitals and asylums.”
 122. *Ibid.*
 123. S.N.B., *Public Health Act*, 50 Victoria, 1878, c 3.
 124. The Department of Health was created in 1918. This was to be the first Ministry of Health in the whole British Empire.
 125. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 9.
 126. *Ibid.*, on p. 9 states that: “Following the war, hospitals began to expand rapidly, becoming the major centres for treatment due to advances in medical science and knowledge. During this period more emphasis was placed on preventive measures, and in response to demands for an expansion of services, new programs began to develop.”
 127. *Ibid.*
 128. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 11. Also, NEW BRUNSWICK DEPARTMENT OF HEALTH, *Province of New Brunswick Report of Health Survey Committee 1951*, p. 57.
 129. *Ibid.*, p. 12.
 130. *Ibid.*
 131. *Ibid.*, states on p. 12. “Although medicare was to be jointly financed by the federal and provincial governments, enormous financial demands were still placed on the New Brunswick government to guarantee minimum services to all citizens. The high costs of providing not only health but other social welfare services as well, created serious problems for the New Brunswick government.”
 132. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, continues on p. 12. “This program was designed to ensure the provision of at least minimum standards of public services on an equal basis throughout the province. Equal opportunity had a major impact on medical service in New Brunswick. It restructured the provincial health care system and emphasized greater efficiency. This program was followed in 1971 with the province’s entry

- into the national medicare plan.” On p. 14 it is stated: “The major impact of Equal Opportunity in the field of health was that local boards of health were abolished and the Department of Health assumed their duties. The Department was entrusted with financial responsibility for providing public health services directly throughout the province with the aim of ensuring basic standards of care for all residents. With the abolition of local boards of health in 1967, local health services were integrated into five health regions designated A-E, each centered on the major urban centres within the province. The plan was to provide a more efficient and coordinated system of care which permitted equity of services for all citizens.” See also L. J. ROBICHAUD, *A Program for Equal Opportunity*, Fredericton, NB, Province of New Brunswick, 1965, p. 7, and NEW BRUNSWICK DEPARTMENT OF HEALTH, *Annual Report, 1967*, p. 238.
133. NEW BRUNSWICK DEPARTMENT OF HEALTH, *Study of Health Facilities in the Province of New Brunswick*, Ottawa, Llewelyn-Davis, 1970, p. 1. It is stated there: “Previous lack of overall coordinated planning has resulted in most communities having their own hospital. While this might appear to accord with the policy of equal opportunity ... it must be emphasized that parity of access to hospital buildings does not necessarily equate with parity of access to hospital services of high quality ... provision of numerous small hospitals can delete the quality of care considerably.” NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, states on p. 15: “The study concluded that for reasons of both quality and economy, hospital services should be concentrated and coordinated within the framework of a regional program, with specialized services grouped together in one place. Under the system in use in 1970, New Brunswick had thirty-eight hospitals with varying standards in the quality of care. Hospitals were too widely scattered and many were too small to provide efficient service. The 1970 study suggested more integration through regional development based on five regions with hospitals at regional, district, and community levels.”
134. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, on p. 15 states: “Between 1950 and 1984, hospitals came into more popular, widespread use and became highly technological organizations with the introduction of modern new equipment such as cat scans and the development of new branches such as nuclear medicine.”
135. NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 15.

