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**THE CANONICAL STATUS OF CATHOLIC HEALTH CARE FACILITIES
IN THE PROVINCE OF NEW BRUNSWICK IN THE LIGHT OF RECENT
PROVINCIAL GOVERNMENT LEGISLATION**

by
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**A dissertation submitted to the Faculty of Canon Law,
Saint Paul University, Ottawa, Canada, in partial
fulfillment of the requirements for the degree of
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ABSTRACT

The presence of the Roman Catholic Church in institutional health care is as old as the history of Canada itself. On July 25, 1869, the first Catholic hospital in the Province of New Brunswick was founded at Chatham by the Religious Hospitallers of Saint Joseph. This marked the beginning of a one-hundred-and-thirty year tradition of caring for and healing the sick. Subsequently, other religious institutes of women founded and administered health care facilities throughout New Brunswick, ranging from hospitals to nursing schools to homes for the aged. At the heart of the Church's health care apostolate lays the affirmation of the dignity of the human person and the strong commitment to give concrete expression to the gospel mandate "to heal the sick."

In March 1992, the provincial health minister announced an overhaul of the health care system in New Brunswick. This legislation threatened the Church's integral mission of providing health care in the Province. The Hospital Act of 1992 terminated unilaterally the collaboration, cooperation and partnership between Government and Church in the area of health care. The take-over of the Catholic hospitals, the dissolution of the individual hospital boards, the establishment of seven regional hospital corporations, challenged and even denied the Church's right to be involved in the health care delivery system.

Obviously, this legislation proved unsatisfactory to the religious institutes owning hospitals in the Province, to the bishops and to the New Brunswick Catholic Health Association. On April 21, 1993, after nearly a year of negotiations, an Agreement was reached whereby Catholic hospital facilities in the Province would continue to be owned by the religious institutes. While administration and control of these same facilities would come under the authority of a regional hospital corporation, provisions were introduced to safeguard Catholic mission, values, philosophy and ethics in these hospitals. The Hospital Act of 1992 was also amended so as to include these guarantees, while, at the same time, establishing Advisory Committees for each of the Catholic hospitals in the Province. These Committees would be the mechanism assuring the protection and promotion of the Catholicity of the hospital facilities.

The canonical status of the Catholic hospitals in New Brunswick has been definitively altered in New Brunswick by the provincial legislation of 1992. However, other health care facilities continue to be owned, administered and controlled by religious in the Province. These facilities make visible in a tangible way the presence of the Healing One who issued the command nearly two thousand years to care for and heal the sick. Canon Law provides the necessary provisions to assist and enhance this apostolic endeavour.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	vi
ABBREVIATIONS	viii
INTRODUCTION	x
 CHAPTER ONE: THE DEVELOPMENT OF HEALTH CARE FACILITIES IN THE CATHOLIC CHURCH AND IN PARTICULAR IN THE PROVINCE OF NEW BRUNSWICK	 1
I. EARLY DEVELOPMENT OF HEALTH CARE	3
A. Pre-Biblical Roots	3
B. Scriptural Reflections on Sickness and Health	5
C. Apostolic Times and the Early Church.....	9
D. Post-Apostolic Times	13
1. Sixth to Eighth Centuries	13
2. Ninth Century	14
3. Middle Ages	15
4. Sixteenth and Seventeenth Centuries	17
 II. DEVELOPMENT OF THE CATHOLIC HEALTH CARE APOSTOLATE IN CANADA	 19
 III. EVOLUTION OF CATHOLIC HEALTH CARE IN THE PROVINCE OF NEW BRUNSWICK	 24
A. The Context	24
B. The Religious Institutes	31
1. Religious Hospitallers of Saint Joseph	31
2. Sisters of Charity of the Immaculate Conception of Saint John	38
3. Soeurs de Notre Dame du Sacré-Coeur	42
4. Les Filles de Jésus	43
C. Health Care in New Brunswick.....	45
 IV. CONCLUSION	 54

TABLE OF CONTENTS

ii

CHAPTER TWO: TOWARDS A DETERMINATION OF CANONICAL STATUS	56
I. THE JURIDICAL PERSON	58
A. Prior to and in the 1917 Code of Canon Law	58
1° Secular Institution	62
2° A Pious Institution	63
3° Ecclesiastical Institutions	64
4° Ecclesiastical Moral Person	66
B. The 1983 Code of Canon Law	69
1. Establishment	71
2. Purpose	72
3. Types of Juridic Persons	73
4. Public and Private Juridic Persons	75
II. ECCLESIASTICAL PROPERTY AND CANONICAL STATUS	76
A. Acquisition and Ownership of Ecclesiastical Property and Ecclesiastical Goods	77
B. Administration of Ecclesiastical Property	81
C. Alienation of Ecclesiastical Property	85
III. CATHOLIC IDENTITY OF A CATHOLIC HEALTH CARE FACILITY	93
A. Canonical Sources and Catholic Identity	94
B. The Catholic Health Care Facility	95
C. Identity Based On Values	101
D. Determining the Catholic Identity of an Institution	104
1. The Institutional Approach	104
2. The Communio Approach	107
3. A Mixed Approach	107
4. Values Approach	108
5. Identity Based on Multiple Factors	109
a) Mission	109
b) Sponsorship and control	110
c) Holistic Care	111
d) Ethics	113

TABLE OF CONTENTS

iii

IV. CONCLUSION.....	114
 CHAPTER THREE: CIVIL LEGISLATION AND THE CATHOLIC HEALTH CARE FACILITY IN NEW BRUNSWICK	 118
I. BACKGROUND TO HEALTH CARE REFORM IN NEW BRUNSWICK	119
A. Health Reports and Various Documents	119
B. A Health and Community Services Plan for New Brunswick	130
C. Bill 23: An Act to Amend the Public Hospitals Act.....	134
D. Reaction to Bill 23	136
II. HOSPITAL ACT 1992: BILL 64.....	139
A. The Hospital Act	139
B. Reaction to the Hospital Act	142
C. Proposal of the New Brunswick Catholic Health Association	144
III. SUBSEQUENT LEGISLATION AND AGREEMENT	147
A. The Letter of Understanding	148
B. Amendments to the Hospital Act	155
C. Required Bylaw Wording for Region Hospital Corporation	157
D. General Position Description for Administrators of Catholic Religious Hospitals Facilities	158
E. Terms of Reference for Advisory Committees	162
F. The Lease for Catholic Hospital Facility	164
IV. CONCLUSION.....	167
 CHAPTER FOUR: TRANSFORMATION AND NEW HORIZONS IN CATHOLIC HEALTH CARE APOSTOLATE	 169
I. EVOLVING MODELS IN CATHOLIC HEALTH CARE	171
A. Unicameral Governance Model	171

TABLE OF CONTENTS

iv

B.	Diocesan Sponsorship Model	174
C.	Sponsorship by Ecclesiastical Provinces	175
D.	Catholic Health Care Group Model	180
E.	Agreements Relinquishing Ownership and/or Governance	183
F.	Provincial Governance Agreement	189
II.	CANONICAL MODELS FOR CATHOLIC HEALTH CARE	190
A.	Associations of the Christian Faithful	190
B.	Private Juridic Person	195
C.	Public Juridic Person	196
III.	VARIOUS ROLES INVOLVED IN PRESERVING CATHOLIC HEALTH CARE APOSTOLATE	198
A.	Role of the Diocesan Bishop	199
B.	Role of the Religious Institute and its Members	201
C.	Role of the Laity in the Health Care Apostolate	202
IV.	THE FUTURE OF THE CATHOLIC HEALTH CARE APOSTOLATE IN NEW BRUNSWICK	203
A.	The Present Situation of Catholic Health Care in New Brunswick	204
B.	Areas Needing to be Addressed	206
C.	New Dimensions for Catholic Health Care in New Brunswick	207
D.	Canonical Models for the Catholic Health Care Apostolate in New Brunswick	209
V.	CONCLUSION	211
	SUMMARY AND GENERAL CONCLUSION	213
APPENDIX A:	BILL 23 AN ACT TO AMEND THE PUBLIC HOSPITALS ACT	223
APPENDIX B:	BILL 64 HOSPITAL ACT (1992).....	231

TABLE OF CONTENTS

v

APPENDIX C:	LETTER OF UNDERSTANDING AND AGREEMENT	282
APPENDIX D:	BILL 82 AN ACT TO AMEND THE HOSPITAL ACT	294
APPENDIX E:	BILL 83 AN ACT TO AMEND THE HOSPITAL ACT	309
APPENDIX F:	NEW BRUNSWICK REGULATION 92-84	317
APPENDIX G;	LETTER OF COMFORT.....	322
APPENDIX H;	REQUIRED BY-LAW WORDING OF REGION HOSPITAL CORPORATION BY-LAW	324
APPENDIX I;	GENERAL POSITION DESCRIPTION FOR ADMINISTRATOR OF CATHOLIC RELIGIOUS HOSPITAL FACILITY	326
APPENDIX J:	TERMS OF REFERENCE: ADVISORY COMMITTEES	330
APPENDIX K:	LEASE	333
BIBLIOGRAPHY.....		341
BIOGRAPHICAL NOTE		375

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ABBREVIATIONS

<i>AA</i>	<i>Apostolicam actuositatem</i>
<i>AAS</i>	<i>Acta Apostolicae Sedis</i>
<i>AG</i>	<i>Ad gentes</i>
c.	canon
cc.	canons
CCCB	Canadian Conference of Catholic Bishops
CCHC	Consolidated Catholic Health Care
<i>CD</i>	<i>Christus Dominus</i>
CHA	Catholic Health Association of the United States
CHAC	Catholic Health Association of Canada
<i>CIC 1917</i>	<i>Codex iuris canonici, Pii X Pontificis Maximi iussu digestus, Benedicti Papae XV auctoritate promulgatus</i>
<i>CIC 1983</i>	<i>Codex iuris canonici, auctoritate Ioannis Pauli PP. II promulgatus</i>
<i>CLD</i>	<i>Canon Law Digest</i>
CLSA	Canon Law Society of America
FLANNERY	<i>Vatican Council II: Conciliar and Post Conciliar Documents</i>
F.J.	Les Filles des Jésus
<i>GE</i>	<i>Gravissimum educationis</i>
<i>LG</i>	<i>Lumen gentium</i>
NCCB	National Conference of Catholic Bishops (United States)
NDSC	Soeurs de Notre Dame du Sacré-Coeur

ABBREVIATIONS

<i>OT</i>	<i>Optatam totius</i>
<i>PO</i>	<i>Presbyterorum ordinis</i>
RHSJ	Religious Hospitallers of Saint Joseph
SCIC	Sisters of Charity of the Immaculate Conception
<i>SRR Dec</i>	<i>Sacrae Romanae Rotae Decisiones</i>
S.N.B.	STATUTES OF NEW BRUNSWICK

INTRODUCTION

Over the course of the centuries the Church has felt strongly that service to the sick and suffering is an integral part of its mission, and not only has it encouraged among Christians the blossoming of various works of mercy, but it has also established many religious institutions within itself, with the specific aim of fostering, organizing, improving and increasing help to the sick. Missionaries, on their part, in carrying out the work of evangelization, have constantly combined the preaching of the good news with the help and care of the sick.¹

John Paul II, in his Apostolic Letter of 11 February 1985, established the Pontifical Council for Health Care Workers. This Council would be a further expression of the importance the Church places on the health care apostolate and the prominence it has assumed. Since gospel times, the Church has remained steadfast in its commitment to carry out the command of Christ to “heal the sick, raise the dead, cleanse the lepers, cast out demons.”²

A variety of means have been employed in actualizing the health care apostolate including miraculous cures; healing through prayer, anointing, and the laying on of hands; and the founding, owning and sponsorship of health care facilities.³ Health care facilities include hospitals, hospices, clinics, homes for the aged, orphanages, special care homes, etc.

¹ JOHN PAUL II, Apostolic Letter, *Motu proprio, Dolentium hominum*, 11 February 1985, in *Origins*, 14 (1984-1985), p. 761.

² MATTHEW 10:7. All future references to scripture are from the Jerusalem Bible.

³ J. CLEARY, “The Church in Health Care: Reflections and Projections,” (= “The Church in Health Care”), in *Hospital Progress*, 63 (1982) 1, pp. 38-39.

Care and concern for the sick and suffering is not an option for the Church. It is a mandate of the Divine Physician. This mandate comes from His many encounters with those in need of healing and wellness. Jesus never turned his back or ran away from sickness and suffering. He confronted it, embraced it and redeemed it. Those who came into contact with Him experienced the compassion and healing presence of God. The ailments of the time were not much different from those of today. Instead of leprosy, dumbness, blindness, epilepsy or a severed ear, it is cardiac disease, Alzheimer's disease, various forms of cancer, and Aids. The call and challenge still remain for a listening ear, an understanding heart, a healing touch.⁴ History attests that "the Catholic Church is the single largest provider of health care in the world, truly faithful to the mission given by Christ to teach and to heal."⁵

Today Catholic health care facilities find themselves in a period of transition. Dramatic changes are occurring due to many factors — changes challenging those involved in the health care apostolate to seek new alternatives if this integral mission of the Church is to continue. Through a respectful use of canon law and civil law, the essential reason for the Church's involvement in health care — to embody and give witness to God's saving power at work — will be preserved and handed on to the next generation.

The presence of the Roman Catholic tradition in institutional health care in this country is

⁴ CLEARY, "The Church in Health Care," p. 38.

⁵ J. CASSIDY, "Catholic Hospitals in the World," in *Dolentium hominum*, 14 (1990) 2, p. 22.

almost as old as the country itself.⁶ From the early Jesuit missionaries at Ste. Marie among the Hurons, through Jeanne Mance and the Religious Hospitallers of Saint Joseph at Montreal, Marguerite d'Youville's founding of the "Grey Nuns" and up to today there has existed a powerful commitment to the care of the sick, the injured and the dying.

The Religious Hospitallers of Saint Joseph⁷ played a key role in bringing the Catholic health care apostolate to the Province of New Brunswick. Responding to the request of Bishop James Rogers of Chatham, the Sisters set out from Montreal in 1868 to administer the leper colony at Tracadie in northeastern New Brunswick. On July 25, 1869 the first Catholic hospital in the Province was founded at Chatham. This marked the beginning of a one-hundred-and-thirty year tradition of caring for and healing the sick in the Province. Subsequently, the Religious Hospitallers went on to found other health care facilities through New Brunswick, ranging from hospitals to nursing schools to homes for the aged. Over the next five decades three other religious institutes — the Sisters of Charity of the Immaculate Conception of Saint John, NB, Les Filles de Jésus, and the Sisters of Notre Dame du Sacré-Coeur — would establish, administer and staff health care facilities in the Province.

At the heart of the Church's health care apostolate lies the affirmation that human life is

⁶ M.G. DOYLE, *The Catholic Hospitals of Canada*. JCD dissertation, Ottawa, ON, University of Ottawa, 1964, pp. 14-120, provides an excellent in-depth historical overview of the Catholic hospitals in Canada.

⁷ The Religious Hospitallers of Saint Joseph in New Brunswick are represented by two provinces — St. Joseph's and L'Assomption-de-Notre-Dame.

sacred at all stages; that the dignity of the human person must be respected and uplifted; that a commitment to the concrete expression of the gospel imperative must be set forth in a visible and tangible manner. The Catholic mission and philosophy in the health care apostolate would be guaranteed and protected in part by owning and administering health care facilities. With the passing of time, the delivery of health care in New Brunswick became affected by the adoption of hospital insurance plans (1958) and the introduction of Medicare (1971). This brought about a partnership and a collaborative effort on the part of government and Catholic health care facilities in an attempt to continue to provide effective and quality health care to the citizens of the Province.

In March 1992, the provincial health minister announced an overhaul of the health care system in New Brunswick.⁸ This legislation, which took effect on July 1, 1992,⁹ threatened the Church's integral mission of providing health care in the Province. The Hospital Act of 1992, Bill 64, terminated unilaterally the collaboration, cooperation and partnership between Government and Church in the provision of health care. The takeover of the Catholic hospitals, the dissolution of the individual hospital boards, the establishment of seven Regional Hospital Corporations, challenged and even appeared to deny the Church's right to be involved in health care. Bill 64 showed no recognition of the role played or the contribution made by the various religious institutes in the delivery of health

⁸ See especially NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Master Plan '92: New Brunswick Hospital System*, Fredericton, NB, Department of Health and Community Services, 1992, 78 p. and by the same Department, *A Health and Community Services Plan for New Brunswick*, Fredericton, NB, Department of Health and Community Services, 1993, 22 p.

⁹ STATUTES OF NEW BRUNSWICK (= S.N.B.), *Bill 64, Hospital Act 1992*, 38 Elizabeth II, C.6, 1992, 46 p.

care services in New Brunswick. The adoption of Bill 64 put in serious jeopardy the Church's right to acquire, retain, administer and alienate health care facilities, especially hospitals. Beyond property issues and beyond questions of ownership of facilities lies the crux of the whole matter — upholding of Catholic values and philosophy, mission and ethics as well as the whole notion of Catholic identity. What role can and does canon law play in regard to these important issues?

The action of the New Brunswick government regarding Catholic health care facilities challenges the Church to re-examine its role. Canon law offers the resources and flexibility needed in determining and providing alternatives to the traditional models of health care and in attempting to live out the gospel mandate “to heal the sick.”

This study will examine the canonical status of Catholic health care facilities, especially hospitals, in the Province of New Brunswick in the light of recent government legislation introduced in 1992.¹⁰ With the Hospital Act of 1992, there was the takeover of the province's seven

¹⁰ Other works consulted pertaining to canonical status include the following: J. CLEARY, *Canonical Limitation on the Alienation of Church Property: An Historical Synopsis and Commentary*. Washington, DC, The Catholic University of America Press, 1963, viii, 141 p. Canon Law Studies, no. 100; J. A. DOYLE, *Civil Incorporation of Ecclesiastical Institutions: A Canonical Perspective*. JCD dissertation, Ottawa, ON, Saint Paul University, 1989, x, 235 p; B. DUNN, *Sponsorship of Catholic Institutions, Particularly Health Care Institutions by the Sisters of Providence in the Western United States*. JCD dissertation, Ottawa, ON, Saint Paul University, 1995, v, 272 p; J. GOODINE, *The Right of the Church to Acquire Temporal Goods*. Washington, DC, The Catholic University of America Press, 1941, viii, 119 p. Canon Law Studies, no. 131; E. HESTON, *The Alienation of Church Property in the United States: An Historical Synopsis and Commentary*. Washington, DC, The Catholic University of America Press, 1941, xv, 222 p. Canon Law Studies, no. 132; F. KORTH, *Canon Law for Hospitals: Administration of Temporal Goods*. St. Louis, MO, The Catholic Health Association of the United States, 1962, vi, 40 p; A. MAIDA, *Ownership, Control and Sponsorship of Catholic Institutions*. Harrisburg, PA, Pennsylvania Catholic Conference, 1975, xi, 75 p; A. MAIDA and N. CAFARDI, *Church Property, Church Finances, and Church*

Catholic hospitals. These were absorbed by regional hospital corporations — placing all administration and control under the authority of the Minister of Health and Community Services.

Obviously, this legislation proved unsatisfactory to the religious institutes owning these facilities, to the bishops and to the New Brunswick Catholic Health Association. As a result, deliberations were held between the Minister and representatives of the above-mentioned groups. On April 21, 1993 an Agreement was reached whereby Catholic hospital facilities would continue to be owned by the four religious institutes. While administration and control of these same facilities would come under the authority of a regional hospital corporation, provision was introduced to safeguard Catholic mission, values, philosophy and ethics in those hospitals. The Hospital Act of 1992 was also amended so as to include these guarantees, while, at the same time, establishing Advisory Committees for each of the Catholic hospitals in the Province. These Committees would be the mechanism assuring the protection and promotion of the Catholicity of the hospital facilities.

There can be no denying that an overhaul of the provincial health care system was necessary. However, what the Hospital Act of 1992 did essentially was to put Catholic involvement in health

Related Corporations: A Canon Law Handbook, St. Louis, MO, The Catholic Health Association of the United States, 1984, xvii, 339 p; J. MCGRATH, *Catholic Institutions in the United States: Canonical and Civil Law Status*, Washington, DC, The Catholic University of America Press, 1968, ix, 48 p; J. MURPHY, *The Governance of Church Institutions and Protection of Catholic Identity with Particular Reference to Ontario, Canada*, JCD dissertation, Romae, Pontificia Universitas Lateranense, 1994, x, 332 p; D. ZORZI, *Towards Altering Canonical Status: A Case for Catholic Universities and Colleges in Canada*, JCD dissertation, Ottawa, ON, Saint Paul University, 1995, 269 p.

care in New Brunswick in jeopardy. With the adoption of the new legislation, Catholic hospitals, as owned and administered by religious institutes for well over a century, became almost non-existent.

The considerable contributions made by the religious institutes and their members are invaluable to the present day system of health care in the Province. The Bill to amend the 1973 Public Hospitals Act and the Hospital Act of 1992 took little account of the significant role played by these dedicated religious women in the provincial health care system. Furthermore, canon law and its role in this whole question was disregarded. There was no recognition of the Church's right to be involved in this apostolate, nor was there any recognition of the Church's right to acquire, retain, administer and alienate ecclesiastical property and goods. The decisions made concerning the fate of the Catholic hospital facilities in New Brunswick were taken unilaterally. Basically, the administration and control of these ecclesiastical properties and goods would by civil legislation become the domain of the government of New Brunswick. By this action, the Catholic hospital facilities in the Province were jeopardized, endangered and threatened. Only after the threat of a Supreme Court challenge on the constitutionality of the government legislation, and serious negotiations on the part of the New Brunswick Catholic Health Association, the religious owners and the bishops, would agreement be reached concerning the involvement of religious groups in provincial health care.

The dissertation will attempt to raise and address certain questions facing Catholic health care facilities in New Brunswick as well as elsewhere throughout the country. Some of these questions are:

- 1- What is the present canonical status of Catholic health care facilities in the Province of New Brunswick?
- 2- What are the values associated with protecting these Catholic facilities?
- 3- Are there new and alternative models that can be applied to Catholic health care facilities as a result of the New Brunswick government's reorganization of the health care system in the Province?
- 4- What does the future hold for the Catholic health care facilities and apostolate and how can canon law safeguard and promote these facilities?

In examining the canonical status of Catholic health care facilities in New Brunswick, different methods will be employed for the various sections of the dissertation. Chapter One deals primarily with the historical development of Catholic health care in the Church and in particular, in the Province of New Brunswick. Using a chronological approach, an understanding and appreciation will be attained of the Church's active role in health care and its importance in the very mission of the Church. A historical analysis will be undertaken in order to gain an appreciation of the New Brunswick situation. This first chapter will lay the basic foundation for dealing with the question at hand.

Chapter Two will focus primarily on the Church's legislation in determining the canonical status of Catholic health care facilities in New Brunswick. Canonical principles surrounding the juridical person in the Church and how it relates to the determination of canonical status will be examined. The notion of the juridical person, prior to 1917 and according to the formal compilation of the Code of Canon Law in 1917, followed by the legislation of the 1983 Code, will be dealt with, as well as the purpose, establishment, and types of juridical persons in the Church. In determining canonical status, legislation concerning ecclesiastical property and goods must be examined. This will entail a discussion on the acquisition, ownership, administration and alienation of ecclesiastical property and goods. Finally, any consideration centred on canonical status must include some discussion on the Catholic identity of an institution, in this case, the health care facility. Here we will deal with a legal presentation of the issues involved.

Employing an investigative and analytic method, Chapter Three will present and examine the secular legislation and its effect on the canonical status of Catholic health care facilities in New Brunswick. In particular, Part One will present some of the background information needed to understand the health care reform in the Province, leading up to Bill 23 amending the Public Hospital Act of 1973 and paving the way for the introduction of Bill 64 — the Hospital Act of 1992. Part Two of the chapter will provide a detailed overview of the new Hospital Act itself, along with reactions and proposals from interested parties affected by the government's legislation. Finally, Part

Three will examine the subsequent legislation and the agreement reached in 1993, by the Province of New Brunswick, the religious owners of hospital facilities and the New Brunswick Catholic Health Association.

Chapter Four entitled “Transformation and New Horizons in the Catholic Health Care Apostolate,” will deal with the developments occurring at the present time to preserve and promote the Catholic health care apostolate throughout Canada. This chapter will focus on the evolving models currently being studied and implemented, as well as on the canonical models available for health care and the various roles necessary for the preservation and promotion of Catholic character and mission. Finally, this chapter will put forward some thoughts on the existing situation of Catholic health care facilities in New Brunswick, along with areas needing to be addressed and canonical models available for this apostolate to continue in the Province.

The Catholic health care apostolate has a long and distinguished history throughout Canada and certainly in New Brunswick. It has a most definitive impact on the delivery of health care in this Province. This attempt to determine its canonical status in the light of the government legislation of 1992 and the subsequent legislation, is made in the hope that its future will be protected and enhanced.

CHAPTER ONE

THE DEVELOPMENT OF HEALTH CARE FACILITIES IN THE CATHOLIC CHURCH AND IN PARTICULAR IN THE PROVINCE OF NEW BRUNSWICK

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 have been 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 chapter 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 the chapter will examine the early development of health care facilities. It

¹ CATHOLIC HEALTH ASSOCIATION OF CANADA, (= CHAC), *Health Care Ethics Guide*. Ottawa, ON, The Catholic Health Association of Canada, 1991, p. 9.

² *Ibid.*, p. 10.

DEVELOPMENT

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 of the chapter. 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 of this chapter 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. By examining these various themes, the chapter presents the necessary background for determining the canonical status of the Catholic health care facility in New Brunswick in light of recent government legislation.

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

³ *The New Encyclopedia Britannica*. (15th ed.), Chicago, Encyclopedia Britannica Inc., 1984, vol. 8, p. 1114.

Throughout the Greek⁴ and Roman Empires,⁵ temples built to the gods of health were a common occurrence. Facilities to treat the sick would usually be 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

⁴ J. WALKER, *Histoire de la médecine* [traduit pars A. MESRITZ, adapté par V. VERVIERS], Belgique, Gérard, 1962, pp. 23-44.

⁵ Ibid., pp. 48-52.

⁶ W. OLSEY, *The Evolution of Modern Medicine*, New Haven, Yale University Press, 1921, pp. 34-83 deals specially with the practice of medicine in the ancient Greek civilization.

⁷ Ibid, see especially pp. 9-17, 17-28, 30-34.

⁸ F. CLEARY, "The Church in Health Care," p. 39.

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, hemorrhage, 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

⁹ CLEARY, "The Church in Health Care," p. 38.

¹⁰ CANADIAN CATHOLIC CONFERENCE OF BISHOPS (= CCCB), *New Hope in Christ: A Pastoral Message on Sickness and Health*, (= *New Hope in Christ*), Ottawa, ON, Concacan Inc., 1983, p. 8.

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

¹¹ CCCB, *New Hope in Christ*, p. 8.

¹² DEUTERONOMY 30:20.

¹³ CCCB, *New Hope in Christ*, p.8.

¹⁴ CLEARY, "The Church in Health Care," p. 38.

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 *Yeshe*, 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

¹⁵ EZEKIEL 47.

¹⁶ ISAIAH 53:5.

¹⁷ CCCB, *New Hope in Christ*. p. 9.

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

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."

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

²² DUFOUR, *Dictionary of Biblical Theology*. p. 544.

²³ Ibid. p. 254.

²⁴ MATTHEW 10:1.

²⁵ MATTHEW 16:17.

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:

- 1) miraculous cures;
- 2) prayer, anointing with oil, laying on of hands; and
- 3) 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

²⁶ ACTS 3:1; 8:7; 9:32; 14:8; 28:8.

²⁷ I CORINTHIANS 12:9 ; 28:30.

²⁸ CLEARY, "The Church in Health Care," pp. 38-39.

²⁹ Ibid., p.39.

³⁰ Ibid.

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

³¹ CCCB, *New Hope in Christ*, p. 13.

³² Ibid.

³³ Ibid.

³⁴ Ibid., p. 14.

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.

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

- 1) establishment of inns for travellers (*xendochia*);
- 2) establishment of infirmaries (*nosocomia*);
- 3) establishment of foundling homes (*brephotrophia*);
- 4) 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

³⁶ F. MOURRET, *A History of the Catholic Church*, (trans. by N. THOMPSON), St. Louis, MO, Herder Book, 1930, vol. 2, p. 474.

³⁷ NASALLI-ROCCA, "History of Hospitals: The Christian Hospital to 1500," p. 159.

³⁸ DOYLE, *The Catholic Hospitals of Canada*. p. 30; cf. MOURRET, *A History of the Catholic Church*, vol. 2, p. 474.

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.

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 Hotel-Dieu in Lyons (542) and Hotel-Dieu in Paris (660) were established. As the different facilities expanded throughout the continent, usually under the direction and vigilance

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.

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 *infirmatorium*, where the sick could receive proper and adequate treatment for their affliction. Second, besides the *infirmatorium*, 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

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-en-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.»

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

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.

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 practicing 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:

- 1) 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;

⁴⁷ NASALLI-ROCCA, "History of Hospitals: The Christian Hospital to 1500," p. 161.

⁴⁸ BECK et al., *Handbook of Church History*, vol. 4, p. 184.

- 2) certain moral issues and medical practices and procedures came into conflict with Church teaching;
- 3) 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

⁴⁹ 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 CLEARY, "The Church in Health Care," p. 39.

⁵¹ Ibid.

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.

⁵² CLEARY, "The Church in Health Care," p. 40.

⁵³ Ibid.

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 vigor and a promising future for the Church.⁵⁶

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, *The Catholic Hospitals of Canada*. 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 DOYLE, *The Catholic Hospitals of Canada*. p. 46.

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, this 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 a thriving mission station

⁵⁷ DOYLE, *The Catholic Hospitals of Canada*, p. 46.

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.

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 Hotel-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 the chapter, mention must be given to the prominent

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.

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

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.

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.

⁶³ SOEURS GRISES DE MONTREAL, *Recueil de Règles et Constitutions à l'usage des filles séculières administratrices de l'Hôpital général de Montréal, dites les Soeurs de la Charité : recueilli 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, [Montreal ?, 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.

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

A. The Context

The Province of New Brunswick is 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, Mailiceets, 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 centered

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.

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, Maliceet, 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 centers 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

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.

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

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."

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

⁷² NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, 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 *Ibid.*, 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.

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 centers, 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. The almshouse doubled as a place of caring as well as providing some form of assistance to the poor, the destitute, the elderly, the crippled, the

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.

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 fireplaces, thus creating a tropical climate which bred infections. The sick often fled

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.

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

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, *The Catholic Hospitals of Canada*. 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.

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 paper 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

⁸³ F. LAJAT, *Le Lazaret de Tracadie et la communauté des Religieuses Hospitalières de Saint-Joseph*. Montréal, Action paroissiale, 1938, 434 p. 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; Les Filles de Jésus, 1903 and 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.

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 and appreciation 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

⁸⁵ DOYLE, *The Catholic Hospitals of Canada*, 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 DOYLE, *The Catholic Hospitals of Canada*, p. 62.

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

⁸⁷ DOYLE, *The Catholic Hospitals of Canada*, p. 62.

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).

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 this group was a French

⁸⁹ In the revised Constitutions of 1991, RELIGIOUS HOSPITALLEERS 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. DEROY-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.

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 labor.⁹³ She would not be disappointed this time. Finally her prayers and years of perservance proved successful. In 1659, permission was granted for three members of the Religious Hospitallers to go to Montreal. On October 20, 1659, Mother

⁹¹ Marguerite Bourgeoys was born in Troyes, France, the captial 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.

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

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.

opened the first Hôtel-Dieu Hospital⁹⁷ 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.⁹⁸ 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 1975.⁹⁹ 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

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 The Religious Hospitallers of St. Joseph previously owned and operated hospitals in Edmundston, St. Basile, Bathurst, Campbellton and Lameque. In 1972, the hospital property and administration located at Edmundston and Lameque were transferred to the New Brunswick government. The administration of the facility at Campbellton was transferred to the New Brunswick government; see Order in Council of the Province of New Brunswick dated December 20, 1972. Also, it should be noted that the administration of a private hospital at Grand Falls, NB, was undertaken by the Religious Hospitallers of St. Joseph from 1964 -1985.

⁹⁹ CHAC, *Directory*, 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.

Perth-Andover,¹⁰⁰ Hôtel-Dieu in St. Quentin,¹⁰¹ Hôpital de l'Enfant-Jésus in Caraquet,¹⁰² and two nursing homes, Foyer St. Joseph at St. Basile,¹⁰³ and Foyer Notre-Dame de Lourdes at Bathurst.¹⁰⁴

2. Sisters of Charity of the Immaculate Conception

In 1852, Thomas Louis Connolly¹⁰⁵ became the second bishop of Saint John, succeeding Bishop William Dollard. The saintly and much respected churchman wasted no time in taking up the

¹⁰⁰ CHAC, *Directory*. 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.

¹⁰¹ 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.

¹⁰² 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.

¹⁰³ 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.

¹⁰⁴ Ibid., 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.

¹⁰⁵ 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.

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.¹⁰⁶

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 perservance 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.

¹⁰⁶ ST. JOSEPH'S HOSPITAL, *75 Years of Caring*, p. 1.

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),¹⁰⁷ Mary Routanne (Sr. M. Frances), Mary Madden (Sr. M. Joseph), and Annie McCabe (Sr. M. Stanislaus)¹⁰⁸ quickly set about caring for the needs of those mentioned in the first Constitution approved by Bishop Connolly.¹⁰⁹ 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

¹⁰⁷ 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, 142 p.

¹⁰⁸ E. LEGERE, *Laus Deo: 1854-1954: Centenary of the Sisters of Charity of the Immaculate Conception*. Saint John, NB, Raphaelite Press, 1955 (?), p. 14.

¹⁰⁹ 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."

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,¹¹⁰ the long tradition of involvement in the health care apostolate by the Sisters of Charity of the Immaculate Conception was taking root.¹¹¹ 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.¹¹²

¹¹⁰ 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.

¹¹¹ ST. JOSEPH'S HOSPITAL, *75 Years of Caring*, p. 1.

¹¹² 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 anesthesia, internal medicine, orthopedics, 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 re-located 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

3. Soeurs de Notre Dame de Sacré-Coeur

The Sisters of Notre Dame du Sacré-Coeur were officially founded in 1924 when fifty-three Acadian members of the Sisters of Charity of the Immaculate Conception 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 community 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 centers. Today members of the 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, the Sisters of Notre-Dame du Sacré-Coeur continue to exercise their original educational and health care apostolates.¹¹³

4. Les 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 basic 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.

¹¹³ 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.

A local parish priest, Father Pierre Noury,¹¹⁴ 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.¹¹⁵ Under its first foundress, Perrine Samson,¹¹⁶ 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.¹¹⁷ 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.

¹¹⁴ A. TROTTIER and J. FOURNIER, *Les Filles de Jésus en Amérique*. Charlesbourg, Impr. Le Renouveau Inc., 1986, p. 17.

¹¹⁵ 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."

¹¹⁶ TROTTIER and FOURNIER, *Les Filles de Jésus en Amérique*, pp. 19-21.

¹¹⁷ 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.

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. ¹¹⁸ 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). ¹¹⁹

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

¹¹⁸ TROTTER and FOURNIER, *Les Filles de Jésus en Amérique*, p. 4.

¹¹⁹ 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.

of just providing basic and rudimentary health care, actual facilities in which the sick could be treated and cared for began gaining popularity.¹²⁰

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.¹²¹

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.

¹²⁰ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 6.

¹²¹ 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 hospitals 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."

Under the terms of the British North America Act in 1867¹²² 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.¹²³

The Public Health Act of 1875 legislated in Britain influenced to a great extent New Brunswick's Public Health Act passed in 1887.¹²⁴ 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.¹²⁵

¹²² NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, 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."

¹²³ Ibid.

¹²⁴ S.N.B., *Public Health Act*, 50 Victoria, 1878, c 3.

¹²⁵ The Department of Health was created in 1918. This was to be the first Ministry of Health in the whole British Empire.

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."¹²⁶

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.¹²⁷

¹²⁶ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 9.

¹²⁷ Ibid., on p. 9 states that: "Following the war, hospitals began to expand rapidly, becoming the major centers 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."

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."¹²⁸ 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.

¹²⁸ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 9.

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.¹²⁹

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.¹³⁰ 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

¹²⁹ 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.

¹³⁰ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 12.

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."¹³¹

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.¹³²

¹³¹ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *Health Care in New Brunswick*, p. 12.

¹³² 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."

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."¹³³ 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

¹³³ 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 centers 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.

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.¹³⁴ 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.

¹³⁴ 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."

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.¹³⁵

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.¹³⁶

CONCLUSION

Chapter One 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.

¹³⁵ 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."

¹³⁶ *Ibid.*, p. 16.

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, the chapter 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 in the Province of New Brunswick. 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.

With this chapter on the historical development of health care facilities concluded, attention now moves to the canonical principles involved in determining the canonical status of Catholic health care facilities in the Province of New Brunswick at this time in history.

CHAPTER TWO

TOWARDS A DETERMINATION OF CANONICAL STATUS

Canonical status hinges on an understanding of certain juridical concepts and principles. Just as natural persons have the right to know their status at law, so too, juridical persons — in this case health care facilities — have the right to know their legal status, both canonically and civilly. By determining the canonical status of Catholic health care facilities in the province of New Brunswick it becomes possible to determine how canon law applies to them, especially in the light of the provincial government's Bill 64.

In the previous chapter, we saw that the health care apostolate in New Brunswick traced its origins to the mid-nineteenth century. Catholic involvement with health care facilities in New Brunswick covers two canonical periods, (a) before and under the 1917 Code of Canon Law¹ and (b) under the 1983 Code of Canon Law.² Before the 1917 Code, the canonical status of Catholic

¹ *Codex iuris canonici, Pii X Pontificis Maximi iussu digestus, Benedicti Papae XV auctoritate promulgatus, praefatione, fontium annotatione et indice analytico-alphabetico ab emo Petro Card. GASPARRI auctus* (= CIC 1917), Civitate Vaticana, Typis polyglottis Vaticanis, 1933, xlvii, 786 p. Partial English translation in S. WOYWOD, *A Practical Commentary on the Code of Canon Law*, revised by C. SMITH, New York, J.F. Wagner, Inc., 1948, 2 vols. All references to canons of the 1917 and 1983 Code of Canon Law are styled c. for canon and cc. for canons.

² *Codex iuris canonici, auctoritate Ioannis Pauli PP. II promulgatus, fontium annotatione et indice analytico-alphabetico auctus* (= CIC 1983), Libreria editrice Vaticana, 1989, xxxii, 669 p. English translation in G. SHEEHY et al. (eds.), *The Canon Law, Letter & Spirit: A Practical Guide to the Code of Canon Law*, prepared by THE CANON LAW SOCIETY OF GREAT BRITAIN AND IRELAND in association with THE CANADIAN CANON LAW SOCIETY, Collegeville, MN, The Liturgical Press, 1995, xxv, 1060 p.

health care facilities could be determined in three possible ways. Firstly, the facility could have been founded by a religious institute or by a diocese. Under the Pio-Benedictine Code, these facilities were viewed as the proper work of a religious institute or part of the apostolic works of a local diocese, and so the facility shared in the canonical status of the institute or diocese, unless otherwise provided. Secondly, the facility could have been established in such a way as to have the canonical status of a distinct juridic person on its own. Thirdly, most, if not all, of the Catholic health care facilities in New Brunswick, i.e., hospitals and nursing homes, were civilly incorporated by the provincial government as charitable institutions. Normally this does not pose a problem for canonical status. However, it is possible that by doing so the canonical status could have changed. In the case of hospitals, the assets, though incorporated, remained attached canonically to the religious institutes.

To help determine the present canonical status of Catholic health care facilities in New Brunswick in the light of provincial government legislation, this chapter will examine three categories of canonical principles involved. Part One will review canonical legislation itself as found in the 1917 and 1983 Codes of Canon Law in reference to juridical personality and its importance in determining canonical status. Part Two will deal with ecclesiastical property and canonical status, more specifically the acquisition and ownership of ecclesiastical property and goods, their administration, and eventual alienation. Part Three will examine the Catholic identity of a health care institution in terms of its canonical sources, the nature of the facility, its identity based on values, and finally, its identity as deriving from multiple factors such as mission, sponsorship, holistic care and ethics. These

three categories — juridic personality, ownership of temporal goods, and recognition of Catholic identity — all help to determine the present canonical status of these health care institutions.

L THE JURIDICAL PERSON

A. Prior to and in the 1917 Code of Canon Law

Health care in the Catholic Church has long been classified as a work of religion, a work of charity. Before the codification of ecclesiastical law in 1917, this apostolate came under the authority of the local bishop. However, health care facilities were usually owned, administered and staffed by religious institutes. Often the health care apostolate was a proper work of a particular institute.³

Before the twentieth century, health care was often provided in the home under the watchful direction of the family physician, helped by other health care workers and family members. They saw hospitalization as a last resort.⁴ As a result, health care facilities were usually small, thus being able to provide more personal care and attention. The period under consideration witnessed great strides in technological advances, and as a result, health care facilities underwent significant expansion.

³ DOYLE, *The Catholic Hospitals of Canada*, p. 125.

⁴ *Ibid.*, p. 124.

Newer and more sophisticated facilities were constructed and others renovated, all in the pursuit of providing quality health care.⁵

With the flurry of activity surrounding improvements in health care came a changing attitude in the minds of the general populace regarding the health care facility. No longer a place to avoid, these facilities were seen as institutions whose *raison d'être* was helping to ease the burden of health care given at home. People soon realized that much better and safer procedures could be administered in caring for the sick by a highly trained and professional personnel in institutions built specifically for that purpose.

Although the 1983 Code of Canon Law now treats of three kinds of persons in the Church: the physical person, endowed with rights and obligations at baptism,⁶ the moral person⁷ and the juridical person, in the 1917 Code, however, juridical persons were known as moral persons.⁸ This Code provided no exact definition of a moral person. However, in the writings of canonists, attempts

⁵ DOYLE, *The Catholic Hospitals of Canada*. p. 127.

⁶ *CIC 1917*, c. 87: "Baptismate homo constituitur in Ecclesia Christi persona cum omnibus christianorum iuribus et officiis, nisi, ad iura quod attinet, obstet obex, ecclesiasticae communionis vinculum impediens, vel lata ab Ecclesia censura."

⁷ *CIC 1983*, c. 113, §1: "Catholica Ecclesia et Apostolica Sedes, moralis personae rationem habent ex ipsa ordinatione divina."

⁸ *CIC 1917*, c. 99: "In Ecclesia, praeter personas physicas, sunt etiam personae morales, publica auctoritate constitutae, quae distinguuntur in personas morales collegiales et non collegiales, ut ecclesiae, Seminaria, beneficia, etc."

were made at formulating a definition. In one commentary, used extensively, a moral person is defined as follows:

A moral person means a juridical entity, a subject of rights, distinct from all physical or natural persons. Such a person comes into being only when constituted by public authority.⁹

Furthermore, moral persons were of two kinds: collegiate and non-collegiate. Bouscaren states:

A moral person is called collegiate if it is made up of a 'college' or group of natural physical persons. Thus a religious order is made up of its members, a chapter of its canons, a board or committee of its members. These are collegiate moral persons. It must be noted that even in these cases the moral person is a legal entity distinct from the physical persons who compose it. A religious order has rights distinct from the sum of the individual rights of its members. It is a distinct legal entity.¹⁰

It is important to keep in mind that a collegiate moral person was to be comprised of no

⁹ T. BOUSCAREN, A. ELLIS, and F. KORTH (= BOUSCAREN et al.), *Canon Law: A Text and Commentary*. (4th rev. ed.), Milwaukee, The Bruce Publishing Company, 1966, p. 89. J. ABBO and W. HANNAN, *The Sacred Canons: A Concise Presentation of the Current Disciplinary Norms of the Church*. 2nd rev. ed., St. Louis, MO, B. Herder Book Co., 1960, vol. I, on p. 144 states that a moral person is, "a juridic entity constituted by an act of a competent authority, existing independently of other persons, and endowed with the capacity of acquiring and exercising rights as well as of contracting obligations, by the means and to the extent determined by the competent authority." Cf. G. MICHIELS, *Principia generalia de personis in Ecclesia: commentarius libri I Codicis juris canonici, canones praeliminares 87-106*, ed. altera penitus retractata et notabiliter aucta, Parisiis, Tornaci, Romae, Desclée, 1955, p. 347; B. BROWN, *The Canonical Juristic Personality With Special Reference to Its Status in the United States of America*, Canon Law Studies, no. 39, Washington, DC, The Catholic University of America, 1927, pp. 88-94; P. GILLET, *La personnalité juridique en droit ecclésiastique spécialement chez les décrétistes et les décrétalistes et dans le Code de droit canonique*, Malines, W. Godenne, 1927, pp. 265-268.

¹⁰ BOUSCAREN et al., p. 89.

fewer than three physical persons.¹¹ On the other hand, a non-collegiate person is described as, “a juridical entity that consists, not of physical persons, but of property and resources or specified things dedicated to some religious or charitable purpose.”¹² Thus, seminaries, hospitals and churches could come under the heading of a non-collegiate moral person. Furthermore, Canon Law considered all moral persons, whether collegiate or non-collegiate, the equivalent of minors.¹³ This being the case, the moral person enjoyed the same protection under the law as minors.¹⁴

In 1940, a Rotal decision by Jullien noted that health care facilities could be placed into one of four classifications. These played an important role in the determination of canonical status.

A hospital in which the infirm are received [...] can be given different types of juridical status according to the circumstances, namely, according to those things which determine its proper species. It can assume the nature of 1° a secular institution; 2° a pious institution or place; 3° an ecclesiastical institution; and 4° a pious foundation [...].¹⁵

¹¹ *CIC 1917*, c. 100, §2: “Persona moralis collegialis constitui non potest, nisi ex tribus saltem personis physicis.”

¹² F. KORTH, *Canon Law for Hospitals: Administration of Temporal Goods* (= *Canon Law for Hospitals*). St. Louis, MO, The Catholic Health Association of the United States and Canada, 1963, p. 3.

¹³ *CIC 1917*, c. 100, §3: “Personae morales sive collegiales sive non collegiales minoribus aequiparantur.”

¹⁴ KORTH, *Canon Law for Hospitals*, p. 3. See also BOUSCAREN et al., *Canon Law: A Text and Commentary*, states on p. 90, “A moral person, collegiate and non-collegiate, is declared to be in the same class as minors, [...], that is, they are to enjoy the same protection under the law. The reason is that all their rights are in the hands of physical persons whose negligence or prodigality might otherwise cause them serious loss.”

¹⁵ “Hospitale in quo infirmi recipiuntur [...] statum iuridicum sortiri possunt pro adiunctis diversum, ut puta, iuxta ea quae ad speciem illam declarandam proprius faciunt, possunt induere naturam: 1°

1° Secular Institution

A public hospital, according to this Rotal decision *cf.* Jullien would fall under the particular classification of being a secular institution. Because the public hospital did not concern itself with religion, canon law had little bearing on it. At times and in some locations, though, the need arose for a secular hospital to be entrusted to a religious institute which would administer the facility; however, the presence and active involvement of the religious in the facility would not alter its juridical status.

The consequences according to canon law for such an institution resulted in its not being directly subject to Church authority. Though the motive behind its existence might have been noble and humanitarian, the institution remained a secular institution. Its temporal goods remained under the direction and authority of the institution and were not classified as ecclesiastical goods. Nor would an institution of this type be an ecclesiastical institution. It would not be established or approved by the competent ecclesiastical authority and, as such, would not exist as an entity according to canon law. ¹⁶

rei profane; 2° instituti seu loci pii; 3° instituti ecclesiastici; 4° piae foundationis [...].” Decision *cf.* JULLIEN, 11 July 1940, in *Sacrae Romanae Rotae Decisiones seu sententiae*. (= *SRR Dec.*) 32 (1940), p. 533.

¹⁶ DOYLE, *The Catholic Hospitals of Canada*, pp. 208-209.

2° A Pious Institution

A pious institution could be founded by a group of dedicated lay persons, whose genuine motive centered on religious and charitable purposes, such as service and care of the sick. This type of institute had no formal ecclesiastical erection, approbation or juridical personality. For all intents and purposes, it remained the work of a private group of interested and devout Catholics striving to be faithful to the call of the gospel message, and desiring to share in the Church's health care apostolate. Even so, according to canon law, provisions were made for supervision and visitation by the local Ordinary.¹⁷ However, according to Jullien's decision, since there had been no ecclesiastical intervention, an institution of this type had no formal ecclesiastical standing.¹⁸

Because it had not received official establishment or approval by the competent ecclesiastical authority, it follows that this institute had no legal standing in the Church. Nevertheless, an institution of this classification, when matters of faith, morals, pious donations and the administration of the sacraments were concerned, was subject to the supervision and vigilance of the local Ordinary.¹⁹

¹⁷ *CIC 1917*, c. 1491, §1: "Loci Ordinarius omnia huiusmodi instituta, etiam in personam moralem erecta et quovis modo exempta, visitare potest et debet."

¹⁸ Cf. decision *cf.* JULLIEN, in *SRR Dec.*, p. 534.

¹⁹ DOYLE, *The Catholic Hospitals of Canada*. pp. 209-210.

3° Ecclesiastical Institutions

The third classification is of direct interest to this present thesis on the canonical status of Catholic health care facilities in New Brunswick since it was the operational mode under which these facilities fell at the time of their establishment. The intervention of the competent ecclesiastical authority raised what was a pious institution to the level of an ecclesiastical institution. The essential difference between the two lies in the establishment of the latter, or at least its approval by the local Ordinary. However, because an institution was classified as “ecclesiastical”, this did not mean that it obtained status as a moral person. The granting of juridical personality had to be explicit in the decree itself. Ecclesiastical institutions did not need juridical personality to operate unless such personality was considered necessary or useful.²⁰

The question of approbation or erection of the ecclesiastical institution is further dealt with in c. 1489, §2.²¹ A decree of erection implied the establishment of an ecclesiastical institution, while an approbation put the seal of approval on an existing one and endowed it with the quality of an ecclesiastical institution. The approval consisted either in approbation of the statutes, or was specifically mentioned in the document of foundation (erection).²²

²⁰ DOYLE, *The Catholic Hospitals of Canada*, p. 212.

²¹ CIC 1917. c. 1489, §2: “Loci Ordinarius haec instituta ne approbet, nisi finis foundationis utilis reapse sit, et talis constituta fuerit dos, quae, omnibus perpensis, sufficiat vel sufficiens fore prudenter praevideatur ad illum assequendum.”

²² DOYLE, *The Catholic Hospitals of Canada*, pp. 210-212.

An important point to keep in mind is that health care facilities, such as hospitals, usually existed without being granted juridical personality on their own. They were already attached to an existing ecclesiastical moral person, such as a diocese or a religious institute. This was the case with many Catholic health care facilities, especially those in the Province of New Brunswick. The facility participated in the moral personality and nature of the institute to which it was attached. For example, it could have the nature of a diocesan institute, or if attached to a religious institute, could be one of several kinds: of pontifical or diocesan right, exempt or non-exempt.²³ What about a hospital? F. Korth states:

A hospital can be set up as an ecclesiastical moral person, that is, as an independent religious house; or it might merely be a part of, or attached to, some other ecclesiastical moral person or independent religious house. A hospital could also be set up as a non-collegiate moral person; it might then be entrusted by the bishop of the diocese to some religious to be administered by them even though it does not belong to them but to the diocese [...].²⁴

M.G. Doyle points out that “this general classification of ‘ecclesiastical institutes’ comprises the greatest number of Catholic hospitals in Canada, and only a few, if any, would possess the quality of being distinct moral personalities.”²⁵

In canon law, the consequences associated with being an ecclesiastical moral institute would

²³ DOYLE, *The Catholic Hospitals of Canada*. pp. 203-204. Cf. KORTH, *Canon Law for Hospitals*, p. 3.

²⁴ KORTH, *Canon Law for Hospitals*, p. 4.

²⁵ DOYLE, *The Catholic Hospitals of Canada*, p. 205.

arise from having been established or approved by the competent ecclesiastical authority. Subsequently, these institutes would be subject to that authority. Their temporal goods would be ecclesiastical goods, hence, they were subject to the provisions of canon law. Indeed, the local Ordinary had the right of vigilance²⁶ over the administration of all ecclesiastical goods in his territory unless the law prescribed otherwise.²⁷

4° Ecclesiastical Moral Person

The fourth classification dealt with facilities that were granted the status of a moral person according to canon law. A Catholic health care facility could be given this title if it fulfilled all the requirements for the granting of juridical personality: 1) it had a spiritual motive, 2) it was useful, 3) its work was stable, and 4) it had a sufficient endowment to sustain the work.

According to canon law, there existed two ways by which juridic personality could be granted: either by the law itself or by a formal decree of the competent ecclesiastical authority.²⁸ The law

²⁶ *CIC 1917*, c. 1519, §1: "Loci Ordinarii est sedulo advigilare administrationi omnium bonorum ecclesiasticorum quae in suo territorio sint nec ex eius iurisdictione fuerint subducta, salvis legitimis praescriptionibus, quae eidem potiora iura tribuant."

²⁷ DOYLE, *The Catholic Hospitals of Canada*, pp. 210-212.

²⁸ *CIC 1917*, c. 100, §1: "Catholica Ecclesia et Apostolica Sedes moralis personae rationem habent ex ipsa ordinatione divina; ceterae inferiores personae morales in Ecclesia eam sortiuntur sive ex ipso iuris praescripto sive ex speciali competentis Superioris ecclesiastici concessione data per formale decretum ad finem religiosum vel caritativum."

could explicitly or implicitly attribute to an entity some quality (e.g., ownership of property) found only with a juridic person, thus implying the granting of juridical personality. On the other hand, a diocesan bishop had within his authority the ability to establish a charitable institution as a juridic person by means of a formal decree (c. 1489, §1).²⁹ Jullien's decision makes clear, however, the stipulation of the canon law requiring that a decree be issued granting juridical personality. The decree was essential. Nothing else would suffice.³⁰ Could juridical personality come about by way of custom? In the mind of Jullien, Michiels and others, this would not be possible. However, perhaps the time has come for a reexamination of this position.³¹

In the granting of juridical personality to an institution, the 1917 Code of Canon Law stipulated very clearly that the statutes should define its constitution and form of government, its purpose, endowment, administrators, the use of its revenue, and the successor of its property if the institution should become suppressed or extinct. Finally, copies of these statutes were to be retained in the appropriate archives.³²

²⁹ *CIC 1917*, c. 1489, §1: "Hospitalia, orphanotrophia aliaque similia instituta, ad opera religionis vel caritatis sive spiritualis sive temporalis destinata, possunt ab Ordinario loci erigi et per eius decretum persona iuridica in Ecclesia constitui."

³⁰ c. JULLIEN, in *SRR Dec.* no. 12, 3°, pp. 534-535. See also MICHIELS, *Principia generalia de personis in Ecclesia*: p. 405. These authors reject the idea that juridical personality can come about in any way other than by the law itself or by formal decree.

³¹ F. MORRISEY, "Juridic Person: A Practical Guide," in *CHAC Review*, 25 (1997) 1, p. 7. and "Church Law's Role in Collaboration," in *Health Progress*, 74 (1993) 9, p. 26.

³² *CIC 1917*, c. 1490, §1: "In tabulis foundationis pius fundator accurate describat totam instituti constitutionem, finem, dotationem, administrationem et regimen, usum reddituum et successionem in bona,

As a consequence of being thus classified, the institution received full status as a person in the Church, with all the rights and obligations associated with it. The ecclesiastical juridic person would have the right of acquiring, possessing, administering and alienating temporal goods.³³ Furthermore, the temporal goods of this institution would be ecclesiastical goods, subject to the provisions of the canons on temporal goods.³⁴ Likewise, the institution would be subject to the vigilance of the local Ordinary.³⁵

casu extinctionis ipsius instituti.”

CIC 1917, c. 1490, §2: “Huiusmodi tabulae duplici exemplari conficiendae sunt, quorum alterum in archivio instituti, alterum in archivio Curiae reponatur.”

³³ *CIC 1917*, c. 1495, §2: “Etiam ecclesiis singularibus aliisque personis moralibus quae ab ecclesiastica auctoritate in iuridicam personam erectae sint, ius est, ad normam sacrorum canonum, bona temporalia acquirendi, retinendi et administrandi.”

³⁴ *CIC 1917*, cc. 1495-1551.

³⁵ DOYLE, *The Catholic Hospitals of Canada*. pp. 212-213.

B. The 1983 Code of Canon Law

The 1983 Code of Canon Law differs from the 1917 Code regarding juridic persons mostly in terminology.³⁶ The only reference to be found in the current Code in regards to moral persons is in canon 113, §1.³⁷ A. Gauthier deals with this canon in the following way:

In this first canon of the section on juridical persons, the expression 'persona moralis' is applied to the Catholic Church and to the Apostolic See: 'The Catholic Church and the Apostolic See have the status of a moral person by divine disposition.' In fact, even though the group in charge of preparing the draft for this part of the Code, when discussing the binomial moral person/juridical person, was thinking above all of associations that somehow exist before they are recognized in law, also understood that the distinction could be used to honour the fact that the Church pre-exists as a 'moral' entity before the intervention of human positive law. Ordinarily, however, the study group preferred not to speak explicitly in the Code of the distinction between moral and juridical persons, since the distinction is above all a doctrinal one. In fact, in 1968, the study group had decided not to mention the Church as a 'moral person'. But the expression was reintroduced in the final revision of the draft, after the last schema had been presented to the pope. By doing so, the legislator obviously intends to underline the fact that the presence of the Church in the juridical order is not constituted by human law: on the contrary, it exists 'from a divine ordination,' since Christ willed a Church endowed with a juridical structure. The Church possesses a public power of divine origin (c. 129 §1), the right to announce the gospel, etc. 'This Church, constituted and organized as a society in this world, subsists in the Catholic Church, governed by the successor of Peter and the bishops in communion with him' (c. 204 §2). It is significant that both the mention of the Church as a 'moral person by divine disposition,' and as 'constituted and organized as a society in this world,' have been introduced in the Code in its final revision. The

³⁶ A. GAUTHIER, "Juridical Persons in the Code of Canon Law," in *Studia canonica*, 25 (1991), p. 81.

³⁷ CIC 1983, c. 113, §1: "Catholica Ecclesia et Apostolica Sedes moralis personae rationem habent ex ipsa ordinatione divina."

use of the expression 'moral person,' even if restricted to the case of the Church in general and the Apostolic See, does point to a certain view of things that considers the distinction moral/juridical applicable in general.³⁸

Again, in the 1983 Code an actual definition of a juridical person is not provided. In order to achieve a common goal, physical persons come together for the sole purpose of forming a stronger and more unified entity. According to canon law, this entity endowed with personhood, has both rights and obligations. In the CLSA commentary on juridical persons, the author states:

By a fiction of law these aggregates of persons (or of things administered by persons) are treated as possessing some of the rights of physical human persons, notably those of acquisition, possession, and transmission of property, as well as a kind of self-determination that is lodged in various members or organs of the body.³⁹

The present Code treats of juridic persons,⁴⁰ or aggregates of persons or things,⁴¹ as the subject of rights and obligations. Thus, juridical persons exist for the express purpose of continuing the Church's mission.

³⁸ GAUTHIER, "Juridical Persons in the Code of Canon Law," pp. 80-81.

³⁹ E. KNEAL, "Physical and Juridic Persons," in J. CORIDEN, T. GREEN, AND D. HEINTSCHEL (eds.), *The Code of Canon Law: A Text and Commentary (= CLSA Commentary)*. New York/Mahwah, Paulist Press, 1985, p. 80.

⁴⁰ *CIC 1917*, c. 113, §2: "Sunt etiam in Ecclesia, praeter personas physicas, personae iuridicae, subiecta scilicet in iure canonico obligationum et iurium quae ipsarum indoli congruunt."

⁴¹ *CIC 1983*, c. 115, §1: "Personae iuridicae in Ecclesia sunt aut universitates personarum aut universitates rerum."

1. Establishment

Juridic persons in the Church are established in one of two ways: by the law itself or by a special concession of the competent ecclesiastical authority, given through a decree.⁴² Among the juridic persons established by the provision of law we could mention: seminaries, public associations of Christ's faithful,⁴³ parishes and religious institutes. Other forms of juridic persons come about only by way of special concession. Canon 312 lists three general levels of ecclesiastical authority in the Church competent to establish public associations, namely, the Holy See, the Conference of Bishops and the Diocesan Bishop.⁴⁴ The same could probably apply to the granting of juridic personality, although, the Code does not address this issue.

⁴² *CIC 1983*, c. 114, §1: "Personae iuridicae constituuntur aut ex ipso praescripto aut ex speciali competentis auctoritatis concessione per decretum data, universitates sive personarum sive rerum in finem missioni Ecclesiae congruentem, qui singulorum finem transcendit, ordinatae."

⁴³ *CIC 1983*, c. 313: "Consociatio publica itemque consociationum publicarum confoederatio, ipso decreto quo ab auctoritate ecclesiastica ad normam can. 312 competenti erigitur, persona iuridica constituitur et missionem recipit, quatenus requiritur, ad fines quos ipsa sibi nomine Ecclesiae persequendos proponit."

⁴⁴ *CIC 1983*, c. 312, §1: "Ad erigendas consociationes publicas auctoritas competens est:
1° pro consociationibus universalibus atque internationalibus, Sancta Sedes;
2° pro consociationibus nationalibus, quae scilicet ex ipsa erectione destinantur ad actionem in tota natione exercendam, Episcoporum conferentia in suo territorio;
3° pro consociationibus dioecesanis, Episcopus dioecesanus in suo cuiusque territorio, non vero Administrator dioecesanus, iis tamen consociationibus exceptis quorum erigendarum ius ex apostolico privilegio aliis reservatum est."

2. Purpose

The purposes of the juridic person in the Church are described in canon 114, §2:⁴⁵

- works of piety: e.g., the promotion of prayer, worship, etc.,
- works of the apostolate: e.g., health care, teaching, etc., in accordance with the doctrine and ethos of the Church,
- works of charity: e.g., feeding the poor, helping the underprivileged, visiting the sick, etc.⁴⁶

These threefold works may be spiritual or temporal:

The works concerned may be of the strictly spiritual order; equally, however, they may belong to the sphere of what some may see as the purely temporal minded, which some might claim to be the exclusive domain of the civil state. In this regard, there should never be overlooked, much less forgotten, the voluntary and often arduous contribution of the Church to the temporal and social endeavours of so many states worldwide.⁴⁷

⁴⁵ *CIC 1983*, c. 114, §2: “Fines, de quibus in §1, intelleguntur qui ad opera pietatis, apostolatus vel caritatis sive spiritualis sive temporalis attinent.”

⁴⁶ A. McGRATH, “Physical and Juridical Persons,” in *The Canon Law: Letter & Spirit: A Practical Guide to the Code of Canon Law*, Collegeville, MN, The Liturgical Press, 1995, p. 65.

⁴⁷ *Ibid.*

Once the goals are established and the purposes presented, it is the decision of the competent ecclesiastical authority whether or not to grant juridical personality. The necessary factors in determining this are twofold: 1) the work must pursue a useful purpose, spoken of already in c. 114, §2, and 2) it must have the means at its disposal to carry out and achieve that purpose. If this is not so, juridical personality ought to be denied. The CLSA commentary makes a useful recommendation:

[...] the ecclesiastical establishment of a juridic person does not in the least assure its possession of rights before the civil polity. Juridic persons within the Church are therefore encouraged, where appropriate, to seek such civil standing also through civil incorporation, or other appropriate steps effective in the civil arena.⁴⁸

3. Types of Juridic Persons

The 1983 Code of Canon Law classifies juridic persons in a much more precise manner than did the previous Code. No longer are they referred to simply as collegiate or non-collegiate. Instead, the more traditional canonical concept of aggregates of persons (e.g., Conference of Bishops), and aggregates of things (e.g., a diocesan trust for holding property) are first used.⁴⁹

⁴⁸ KNEAL, "Physical and Juridic Persons," p. 81.

⁴⁹ *CIC 1983*, c. 115, §1: "Personae iuridicae in Ecclesia sunt aut universitates personarum aut universitates rerum."

Then, a further distinction is made by dividing the aggregates of persons into collegial and non-collegial.⁵⁰ Membership in the collegial person must be at least three persons to allow for a greater representation and for a majority in any necessary voting procedures. The members of the collegial person determine the activity of the juridic person and make the decisions affecting the undertaking. Examples of a collegial person would be a chapter of a religious institute or a cathedral chapter of canons where they still exist. On the other hand, in non-collegial persons decisions are made by the persons to whom they are entrusted, i.e., a diocese, a parish, or a seminary. A third distinction deals with juridic persons made up of aggregates of things, known as autonomous foundations in canon law.⁵¹ These autonomous foundations are directed by the physical person(s) selected according to the statutes. These may also act as one or several persons or a college, individuals, depending on the statutes.

⁵⁰ *CIC 1983*, c. 115, §2: “Universitates personarum, quae quidem nonnisi, ex tribus saltem personis constituti potest, est collegialis, si eius actionem determinant membra, in decisionibus ferendis concurrentia, sive aequali iure sive non, ad normam iuris et statutorum; secus est non-collegialis.”

⁵¹ *CIC 1983*, c. 115, §3: “Universitates rerum seu fundatio autonoma constat bonis seu rebus, sive spiritualibus sive materialibus, eamque, ad normam iuris et statutorum, moderantur sive una vel plures personae physicae sive collegium.”

4. Public and Private Juridic Persons

The 1983 Code of Canon Law makes the following distinction regarding juridic persons: they are either public or private.⁵² Concerning this distinction, E. Kneal writes in the *CLSA Commentary*:

Juridic persons are considered as 'public' or as 'private'. Those which are public act officially on behalf of the competent ecclesiastical authority by whom they are constituted, and in a larger sense on behalf of the entire Church although always of course within their own limits of competency. Those aggregates of persons or things which are not so empowered by the authority remain only private.⁵³

A public juridic person acts in the name of the Church and represents the Church in an official capacity. On the other hand, the private juridic person, as an aggregate of persons or things, acts in its own name and is under the responsibility of its members. Public juridic personality is conferred through the law itself, or by a special decree of the competent authority. The status of a private juridic person is conferred through a special decree of the competent ecclesiastical authority expressly granting it.⁵⁴ Before public or private juridic personality is conferred on an aggregate of persons or

⁵² *CIC 1983*, c. 116, §1: "Personae iuridicae publicae sunt universitates personarum aut rerum, quae ab ecclesiastica auctoritate competenti constituuntur ut intra fines sibi praestitutos nomine Ecclesiae, ad normam praescriptorum iuris, munus proprium intuitu boni publici ipsis commissum expleant; ceterae personae iuridicae sunt privatae."

⁵³ KNEAL, "Physical Persons and Juridic Persons," p. 82.

⁵⁴ *CIC 1983*, c. 116, §2: "Personae iuridicae publicae hac personalitate donantur sive ipso iure sive speciali competentis auctoritatis decreto eandem expresse concedenti; personae iuridicae privatae hac personalitate donantur tantum per speciale competentis auctoritatis decretum eandem personalitatem expresse concedens."

things, its statutes⁵⁵ are to be approved by the competent authority.⁵⁶ This condition applies to those juridic persons established by decree, such as private associations, private autonomous foundations, and public associations.

II. ECCLESIASTICAL PROPERTY AND CANONICAL STATUS

Thus far, we have dealt with the concept of juridical personality in determining canonical status. Attention now is given to a second factor, that of the acquisition, ownership, administration and alienation of temporal goods. In the Church, regulations and guidelines concerning temporal goods in terms of responsibilities, procedures and policies are governed by the Code and, in the case of goods of religious institutes, by the applicable proper law.

In the present Code, Book V, in four titles and fifty seven canons, deals with the Acquisition of Temporal Goods (cc. 1259-1272), the Administration of Goods (cc. 1273-1289), Contracts and

⁵⁵ *CIC 1983*, c. 94, §1: “Statuta, sensu proprio, sunt ordinationes quae in universalibus sive personarum sive rerum ad normam iuris conduntur, et quibus definiuntur earundem finis, constitutio, regimen atque agendi rationes.”

§2: “Statutis universitatis personarum obligantur solae personae quae legitime eiusdem membra sunt; statutis rerum universitatis, ii qui eiusdem moderamen curant.”

§3: “Quae statutorum praescripta vi potestatis legislativae condita et promulgata sunt, reguntur praescriptis canonum de legibus.”

⁵⁶ *CIC 1983*, c. 117: “Nulla personarum vel rerum universitas personalitatem iuridicam obtinere intendens, eandem consequi valet nisi ipsius statuta a competenti auctoritate sint probata.”

Alienation (cc. 1290-1298) and Pious Dispositions and Pious Foundations (cc. 1299-1310). The corresponding canonical provisions for religious institutes are treated at cc. 634-640.

A. Acquisition and Ownership of Ecclesiastical Property and Ecclesiastical Goods

The basic principles governing the ownership of ecclesiastical property are found in the introductory canons of Book V, namely, cc. 1254-1258. Canon 1254 states the Church's inherent right to acquire, retain, administer and alienate temporal goods, independent of civil authority, in the pursuit of its proper objectives:⁵⁷ divine worship, fitting support for the clergy and other ministers, and carrying out the works of the sacred apostolate and of charity.⁵⁸ Above all, temporal goods serve the Church's mission — to educate, care for the sick, evangelize, etc.

Bishop J. Myers in his commentary defines temporal goods as follows:

⁵⁷ *CIC 1983*, c. 1254, §1: "Ecclesia catholica bona temporalia iure nativo, independenter a civili potestate, acquirere, retinere, administrare et alienare valet ad fines sibi proprios prosequendos."

In the *CIC 1917*, (cc. 1495, §2, 100, 531, and 676) this same right was extended to individual churches (dioceses, prelatures, abbaties nullius, perfectures and vicariates apostolic). See BOUSCAREN et al., *Canon Law: A Text and Commentary*. p. 805.

⁵⁸ *CIC 1983*, c. 1254, §2: "Fines vero proprii praecipue sunt: cultus divinis ordinandus, honesta cleri aliorumque ministrorum sustentatio procuranda, opera sacri apostolatus et caritatis, praesertim erga egenos, exercenda."

Temporal goods as employed in Book V may be understood as all those non-spiritual things which possess economic value. They may include real property as well as intangible rights and assets.⁵⁹

According to canon law, only the juridical person (e.g., Sisters of Charity, Religious Hospitallers of Saint Joseph, Filles des Jésus, Soeurs de Notre Dame du Sacré-Coeur), is capable of owning ecclesiastical goods for the express purposes found in the law.⁶⁰ A. Maida and N. Cafardi in their study on ecclesiastical property make the following observations:

When property belongs to the incorporated apostolate of a public juridic person, e.g., a hospital, the canon law does not recognize the civil law separateness of these assets as accomplished by the apostolates' separate incorporation. Rather, the canon law considers such property to remain that of the sponsoring juridic person and thus to be ecclesiastical property. The civil law characterizes this ownership a bit differently. In civil law, the owner of a non-profit corporation is the non-profit corporation itself. Civil law, unlike canon law, does not recognize the ownership of incorporated apostolates as pertaining to the sponsoring religious or diocesan body; this is fitting, since the entire purpose of the civil law incorporation is to create entities legally separate from the sponsor. The canon law does not recognize this separation, however, which is critical, because it therefore considers such incorporated apostolates to remain ecclesiastical property.⁶¹

⁵⁹ J. MYERS, "The Temporal Goods of the Church," in *CLSA Commentary*, p. 859. Cf. DOYLE, *The Catholic Hospitals of Canada*, treats this subject extensively on pp. 214-265. Cf. BOUSCAREN et al., *Canon Law: A Text and Commentary*, p. 805.

⁶⁰ *CIC 1983*, c. 1255: "Ecclesia universa atque Apostolica Sedes, Ecclesiae particulares necnon alia quaevis persona iuridica, sive publica sive privata, subiecta sunt capacia bona temporalia acquirendi, retinendi, administrandi et alienandi ad normam iuris." See also *CIC 1983*, c. 634 § 1.

⁶¹ A. MAIDA and N. CAFARDI (= MAIDA and CAFARDI), *Church Property, Church Finances and Church-Related Corporations: A Canon Law Handbook*, (= *Church Property*), St. Louis, MO, The Catholic Health Association of the United States, 1984, pp. 75-76. Cf. A. MAIDA, *Ownership, Control and Sponsorship of Catholic Institutions*, Harrisburg, PA, Pennsylvania Catholic Conference, 1975, pp. 32-37. J. MCGRATH, *Catholic Institutions in the United States: Civil and Canonical Implications*, Washington,

Canon 1256 provides that the ownership of ecclesiastical goods belongs to that juridic person who lawfully acquired those goods.⁶² What is meant by “ownership” in the canonical sense of the word? J. A. Doyle states that canonical ownership is

a juridical condition of a relationship between a capable subject and its temporal goods that arises in virtue of a specific purpose. This relationship entitles the person to exclude the claim of any other person relative to those goods, while at the same time preventing the owner from using them for any other purpose. As long as the relationship between the person and the goods is based on the legitimate purpose, the condition of canonical ownership endures. If the goods pass to another owner who does not have the required canonical capacity, or if they are used for some other purpose, the condition of ownership becomes either non-canonical or illegitimate.⁶³

It must be pointed out here that ownership in canonical terms does not have exactly the same meaning it does in civil law. The notion of canonical ownership derives its meaning from Roman Law which, like the Code, uses the term *dominium*. J. Myers states that

dominium in Roman law was close to being absolute, i.e., the owner was clearly identifiable over and against all other persons and his interest was undivided and

DC, Catholic University of America, 1968, pp. 19-24.

⁶² *CIC 1983*, c. 1256: “*Dominium bonorum, sub suprema auctoritate Romani Pontificis, ad eam pertinet iuridicam personam, quae eadem bona legitime acquisiverit.*”

⁶³ J.A. DOYLE, *Civil Incorporation of Ecclesiastical Institutions: A Canonical Perspective*, JCD dissertation, Ottawa, ON, Saint Paul University, 1989, p. 113. The author continues by stating: “The determination of the terms of this relationship in regard to the capable subject, to the legitimate purposes and even to the goods themselves is a function of the canonical system. No person, physical or juridical, on the basis of an independent action, can claim to be a capable subject, but must be constituted as such by the competent authority, nor can any particular subject recognize legitimate purposes which are not proper to the Church. Thus, the juridical person and the temporal goods are integrated into the canonical order, which is the society of the Church. The relationship of purpose between that person and its goods is a particular expression of the inherent right to temporal goods which is claimed by the Church. There is, then, a unity of purpose for persons and things in the Church which is realized in each incident of canonical ownership.”

complete. No other person was entitled to regard the things as his and no other person could have taken possession of or use of the thing without the consent of the person having *dominium*.⁶⁴

Temporal goods and their ownership are the subject of canon 1257.⁶⁵ They belong to the entire church, to the Apostolic See or to other juridic persons such as a diocese, parish, religious institute,⁶⁶ seminary, university, hospitals, etc. Much discussion surrounded this canon during the revision process due to the division of juridic persons into public and private. Only the temporal goods of the public juridic person are to be considered ecclesiastical goods.⁶⁷ Those belonging to the

⁶⁴ MYERS, "The Temporal Goods of the Church," pp. 862-863. The author further points out that "three rights are usually included in the concept of *dominium*: the right to make physical use of a thing and to possess it (*utendi*); the right to income gained from it in money, kind, or services (*fructuendi*); and the right to manage it— well or badly — including conveying it to someone else (*abutendi*). The social policy was to keep these three rights as closely associated as possible — although some exceptions were made — particularly regarding the right to income." For further studies on the concept of ownership and *dominium*, consult B. NICHOLAS, *An Introduction to Roman Law*. Oxford, Clarendon Press, 1962, pp. 153-157.

⁶⁵ *CIC 1983*, c. 1257, §1: "Bona temporalia omnia quae ad Ecclesiam universam, Apostolicam Sedem aliasve in Ecclesia personas iuridicas publicas pertinent, sunt bona ecclesiastica et reguntur canonibus qui sequuntur, necnon propriis statutis." See also *CIC 1983*, c. 635, § 1.

c. 1257, §2: "Bona temporalia personae iuridicae privatae reguntur propriis statutis, non autem hisce canonibus, nisi expresse aliud caveatur."

⁶⁶ RELIGIOUS HOSPITALERS OF SAINT JOSEPH, *Constitutions and Rules of the Religious Hospitallers of Saint Joseph*. Montreal, Religious Hospitallers of Saint Joseph, 1991, p. 133. SISTERS OF CHARITY OF THE IMMACULATE CONCEPTION, *Called To Be With Him: Constitutions of the Sisters of Charity of the Immaculate Conception*. Saint John, NB, Sisters of Charity of the Immaculate Conception, 1983, p. 135.

⁶⁷ According to J. HITE, "The Temporal Goods of the Church," in *Readings, Cases, Materials in Canon Law for Ministerial Students*. Collegeville, MN, The Liturgical Press, 1990, p. 407, "ecclesiastical goods or church property are defined by who owns the property ... according to c. 1257." E. HESTON, in his work, *The Alienation of Church Property in the United States: A Historical Synopsis and Commentary*. Washington, DC, The Catholic University of America Press, 1941, *Canon Law Studies*, no. 132, states on pp. 79-80 that "ecclesiastical goods are understood to be all those things, movable or immovable, money or income from money, which have been or are given by the faithful, or which accrue to the Church from goods already possessed which have been given to the Lord for religious purposes, for the carrying out of divine

private juridic person are governed by the provisions of its statutes. It was the fear of some consultors that the temporal goods of these 'persons' would go unsupervised.⁶⁸ However, if the statutes are well developed, clear, and precise this need not cause any worry.

B. Administration of Ecclesiastical Goods

The administration of ecclesiastical goods is the focus of cc. 1273 - 1289. J. Myers in his commentary on these canons states that

administration in this context refers to those actions or sets of actions which are directed to preserving church property; improving property or resources; managing the collection and distribution of income from a variety of sources, including the offerings of the faithful and return on investments. It also includes keeping accurate records and properly reporting income and expenses.⁶⁹

worship, for the acquisition and support of schools, hospitals, orphanages, monasteries and convents, and are therefore rightly called 'ransom from sin,' the expression of the prayers of the faithful, and the patrimony of the poor." Concerning the subject of ecclesiastical goods, HESTON quotes from *Summa theologiae moralis*, 5th ed., Romae, 1908, III, n. 77, which states: "ecclesiastical goods are those which are possessed by ecclesiastical persons and, therefore, by ecclesiastical authority." BOUSCAREN et al., *Canon Law: A Text and Commentary*, states on p. 807 the following: "ecclesiastical goods (church property) are all temporal goods (whether corporeal or incorporeal, movable or immovable) which belong to the Church universal and the Apostolic See, or to some other moral person in the Church."

⁶⁸ F. VOTO, "Coetus studiorum de bonis Ecclesiae temporalibus," in *Communicationes*, 12 (1980), pp. 398-399.

⁶⁹ MYERS, "The Temporal Goods of the Church," p. 870. J. COMYNS, *Papal and Episcopal Administration of Church Property*. Washington, DC, The Catholic University of America Press, 1942. Canon Law Studies, no. 147, states on p. 1: "Administration, as applied to ecclesiastical property, is defined as: the control or care of the temporal goods of the Church in order that they may serve the purposes for which they were acquired. This definition includes all acts which are necessary or useful: (1) to keep the property in good condition; (2) to make it productive; (3) to derive benefit from it; (4) to apply, pay out and

Basically, the administration of ecclesiastical goods is sometimes termed “canonical stewardship”, since someone must act on behalf of the public juridic person. This is so in order to safeguard what lawfully belongs to that juridic person. A. Maida and N. Cafardi write:

When any of these entities, e.g., a diocese or a religious institute, sponsors an incorporated apostolate such as a health care facility or a college, the proper canonical administrators of the sponsored institution are the same as those of the sponsoring public juridic person.⁷⁰

The duties of the administrator of ecclesiastical goods belonging to the public juridic person are to be found in c. 1284, §2. The canon states that the administrator⁷¹ is to:

1° be vigilant that no goods placed in their care in any way perish or suffer damage; to this end they are, to the extent necessary, to arrange insurance contracts;

use it for legitimate purposes.” J. McMANUS, *The Administration of Temporal Goods in Religious Institutes*. The Catholic University of America Press, Washington, DC, 1937, Canon Law Studies, no. 109, p. 12. HITE, *The Temporal Goods of the Church*, on p. 412 states that “church law provides norms for the care and use of ecclesiastical goods (property).”

⁷⁰ MAIDA and CAFARDI, *Church Property*. p. 61.

⁷¹ HITE, “The Temporal Goods of the Church,” p. 413, states that “the administrator has the responsibility to ensure church property is used in a manner that is consistent with the purpose and teachings of the Church.” The author continues by describing administrative acts as being ordinary or extraordinary. Ordinary administrative acts are those “performed with permission of a higher authority — these are the day to day operations of the public juridic person or its works (e.g. bills, salaries, utilities, collection of income, necessary repairs). Acts are extraordinary because of the nature or importance of the act itself, or its financial value, or because they require the permission of a higher authority (e.g., [...] acceptance or refund of major bequests, purchase of land, construction of new buildings, extensive repair of buildings, expenditures over a certain amount).”

2° ensure that the ownership of ecclesiastical goods is safeguarded in ways which are valid in civil law;⁷²

3° observe the provisions of canon and civil law, and the stipulations of the founder or donor or lawful authority; they are to take special care that damage will not be suffered by the Church through the non-observance of the civil law;⁷³

4° seek accurately and at the proper time the income and produce of the goods, guard them securely and expend them in accordance with the wishes of the founder or lawful norms;

5° at the proper time pay the interest which is due by reason of a mortgage or pledge, and take care that in due time the capital is repaid;

6° with the consent of the Ordinary make use, for the purposes of the juridical person, of money which is surplus after payment of expenses and which can be profitably invested;

7° keep accurate records of income and expenditure;

8° draw up an account of their administration at the end of each year;

⁷² Regarding c. 1284, §2, 2°, the commentator in E. CAPARROS, M. THÉRIAULT, and J. THORN (eds.), *Code of Canon Law Annotated*, Latin-English edition of the *Code of Canon Law* and English-language translation of the 5th Spanish edition of the commentary prepared under the responsibility of the Instituto Martín de Azpilcueta, Montréal, University of Navarra, Faculty of Canon Law and Saint Paul University, Faculty of Canon Law, Wilson & Lafleur Limitée, 1993, points out on p. 796 that "the recognition of the ownership of ecclesiastical goods by secular law should be interpreted in a broad sense and applied both to ownership and to all other real rights, not only regarding validity, but also juridical effectiveness. This is a complementary norm to the 'canonization' prescribed by c. 1290; it refers, primarily to the appropriate registration of immovable property in the name of the juridical person to whom it belongs."

⁷³ The same commentator continues on p. 796 by stating that: "Paragraph 2, 3°, repeats the need to observe secular laws to prevent the Church from suffering any damage, arising either from invalidity of canonical acts or because of their civil unlawfulness. Consequently, all civil, administrative, commercial, fiscal and other secular norms must be followed, since failure to do so could entail civil penalties, loss of goods or their value, the prescription of actions, the mandatory imposition of charges, costly judicial proceedings, etc."

9° keep in order and preserve in a fitting and secure archive the documents and records establishing the rights of the Church or institute to its goods; where conveniently possible, place authentic copies in the archives of the curia.

Of special concern to the subject matter at hand is c. 1284, §2, 2° and 3°. Maida and Cafardi state that the administrator of ecclesiastical goods is required by law to see to it that this ecclesiastical property is properly registered according to the norms provided by civil law. In the case of real estate, it is essential that this be registered at the civil registry office. In this way easy access to documentation proving ownership is available to all concerned should a dispute arise concerning the ownership of the ecclesiastical property. It is of utmost importance that the correct civil law procedures be followed by the canonical administrator. It is also in the best interest of the diocese, parish, and religious institute that the norms spelled out in law are adhered to so as to provide the necessary protection of ownership of ecclesiastical property.⁷⁴

Canon 1284, §2, 3° follows in the same vein as the previous requirement. The canonical administrator of ecclesiastical goods is required to follow both sets of laws, canon and civil, in carrying out the activities of the public juridic person. Take, for example, the health care facility. Today this facility is normally a separately incorporated entity standing on its own from the juridic person of the diocese or religious institute. However, this does not dispense the administrator from carrying out the provisions of canon law. In the civil act of incorporation, the provision to observe

⁷⁴ MAIDA and CAFARDI, *Church Property*. pp. 68-69.

canon law should be somehow included so that administrators fulfill their responsibilities in both realms.

Maida and Cafardi quickly point out that failure to observe the requirements according to civil law and canon law could place ecclesiastical goods in jeopardy. As a matter of fact, failure to insist that civil law be followed could result in actions violating canon law and not serving the best interests of the Church. Finally in paragraph 2, 3°, the canonical administrator is charged with honouring the intention of the donor of ecclesiastical goods. Again this could entail observing the requirements of the civil law, e.g., payment of appropriate taxes.⁷⁵

C. Alienation of Ecclesiastical Goods

In Title III of Book V, cc. 1290-1298 address the difficult and complex notion of the alienation of ecclesiastical goods. Alienation, in the proper sense of the word, can be described as any action by which the right to ownership of ecclesiastical property is transferred to another.⁷⁶

⁷⁵ MAIDA and CAFARDI, *Church Property*, pp. 69-71. See also HITE, "The Temporal Goods of the Church," p. 413 on the specific duties of the administrator of ecclesiastical property.

⁷⁶ F. MORRISSEY, "The Alienation of Temporal Goods," in *Studia canonica*, 29 (1995), p. 294. Also see, HESTON, *The Alienation of Church Property in the United States*, p. 69 where the author states that etymologically the term alienation means "making something become the property of another, or making it a part of someone else's goods. Juridically it means the transfer of the direct ownership of an object to another by means of sale, gift or exchange." J. CLEARY, *The Canonical Limitation on the Alienation of Church Property: An Historical Synopsis and Commentary*, Washington, DC, The Catholic University of America Press, 1963, Canon Law Studies, no. 100, using the thinking of the time, states on p. 2 that "canonically, then, alienation may be defined as any act or contract whereby church property is exposed to danger of loss, or its legal possession is reduced to a worse condition. It is that act by which property, real right, or possession of any ecclesiastical moral person is gratuitously or onerously transferred, set aside, lessened, or

Canon 1291⁷⁷ speaks of alienation as the transfer of goods from the stable patrimony⁷⁸ of a juridic person, e.g., the sale of property from one to another. In a broader sense, and according to some authors, "alienation may be defined as any transaction by which the condition of the public juridic person's patrimony might be jeopardized."⁷⁹

burdened." CLEARY continues on p. 7 by stating that "the canons on alienation concern not only parish property but also hospitals, orphan asylums, seminaries, and other ecclesiastical entities which are canonically established moral persons and can own property. A parish society or a church society must be established as an ecclesiastical moral person by the authority of the local Ordinary before its property can be considered as church property."

⁷⁷ *CIC 1983*, c. 1291: "Ad valide alienanda bona, quae personae iuridicae publicae ex legitima assignatione patrimonium stabile constituunt et quorum valor summam iure definitam excedit, requiritur licentia auctoritatis ad normam iuris competentis." See also *CIC 1983*, c. 638, § 3.

⁷⁸ HESTON, *The Alienation of Church Property in the United States*, on pp. 72-73 describes stable patrimony as "including all those assets which are not in ordinary circulation, as mediums of barter or exchange, but which constitute the permanent basis of a church body's financial security. It is that sum which has been legitimately set aside to remain intact and be a source of regular income. This stable capital may consist of actual cash deposited at interest in a bank; in securities which bring an income either in interest or in dividends; or in real estate which is rented or leased, etc., as a means of procuring steady income. All these categories of assets constitute stable capital or patrimony. The general principle, to which reference has already been made is that alienation is had only when this stable capital or patrimony is diminished." B. SWEENEY, *The Patrimony of an Institute in the Code of Canon Law: A Study of Canon 578*, JCD dissertation, Roma, Pontificia Studiorum Universitas a S. Thoma Aq. In Urbe, 1995, on pp. 7-8 describes patrimony as "a concept that comes from Roman Law. Initially patrimony was understood as goods inherited from a father by succession. The vision of Roman jurisprudence gradually extended to a broader concept of patrimony as the complex of juridic situations, both active and passive, to which a juridic subject has title. In modern English usage, patrimony, in general, is defined as property inherited from one's father, or the endowment of a church. Figuratively it is applied to things (usually immaterial) received or inherited from ancestors or predecessors, or anything inherited as a trait or characteristic." The author continues by describing on p. 8 patrimony as being "the common heritage of a group or society — the ensemble of its art, literature, music, culture, customs, monuments, learning and law. It can also be understood as those intangible qualities of mind, heart, culture and spirit, inherited from a loved one."

⁷⁹ MAIDA and CAFARDI, *Church Property*, p. 85. It should be noted, though, that the 1983 Code does not consider such acts to be acts of alienation, but rather as acts to which the procedures for alienation are to be applied.

A even broader interpretation is applied by canonists who would further describe alienation as “an act by which the use of the right, or the right itself of ownership is or could be diminished, restricted, or endangered.”⁸⁰ The norms governing alienation would also apply to any reduction in the control of ownership, any action that puts in jeopardy the stable patrimony of a public juridic person, e.g., mortgage, lease, rental, lien, etc. Today, loss of control over ecclesiastical property could be considered an action to which the norms on alienation apply. Furthermore, under these norms we could include any act subjecting ecclesiastical property to a permanent or a long term burden, e.g., surety for others, contracting debts.

F. Morrissey, in his recent study on the alienation of temporal goods, outlines six transactions to which the canons on alienation would apply. They include:

a) Any act by which title to property (ownership) is transferred to another, the most common form of such is a sale of land or goods.

b) Spending a part or all of immobilized goods for some purpose other than that for which they were originally immobilized. For instance,

- conveying to other persons, for whom they were not originally intended, money and investments if these latter have become part of the fixed or stable capital of the public juridic person;

- withdrawal, for other purposes, of money or investments from the fixed capital of a juridical person;

- conveyance to others of money or its equivalent, such as stocks, bonds, bank notes, certification of deposit, and the like, received from the sale of property belonging to the fixed capital of the juridical person;

⁸⁰ MAIDA and CAFARDI, *Church Property*. p. 85.

- transfer to others of money or securities received in the form of annuities contingent upon payment of certain annual sums;
 - transfer of money or securities from pious foundations, Mass foundations, bursaries, endowments, annuities, and the like, and more particularly so if the obligations have not yet been acquitted;
 - conveyance of money and securities being diverted from specific purposes for which they were originally acquired.
- c) Acts which are a preparation for conveyance, such as giving security, a mortgage, an option, compromise, settlement.
- d) In general, acts by which church property is subjected to burdens either in perpetuum or for a long time, such as granting the use and usufruct of the property, or easements of various kinds.
- e) The sale of precious works or the conveyance of notable relics.
- f) According to some canonists, establishing a trust would also constitute an alienation since the goods are no longer at the sole disposition of the juridical person.⁸¹

Besides the above-mentioned, other acts could place in jeopardy the stable patrimony of the public juridic person. They include the following:

- a) borrowing money;
- b) taking out a mortgage;

⁸¹ MORRISEY, "The Alienation of Temporal Goods," pp. 295-296. Cf. MAIDA and CAFARDI, *Church Property*, p. 85. For an understanding of this in the *CIC 1917*, see BOUSCAREN et al., *A Text and Commentary*, p. 838 as well as W. DOHENY, *Practical Problems in Church Finance*. Milwaukee, WI, Bruce Publishing Co., 1941, pp. 44-45.

c) entering into a long-term lease;⁸²

d) changing the status of ownership, such as turning over certain properties to secular boards.⁸³

One of the requirements necessary for the valid alienation of ecclesiastical goods is the permission of the appropriate competent authority. This is addressed in canon 1292.⁸⁴ In an attempt to apply the principle of subsidiarity, the canon gives to the Conference of Bishops the authority to determine minimum and maximum amounts in regard to alienation of ecclesiastical goods. Below the

⁸² See CONGREGATION FOR INSTITUTES OF CONSECRATED LIFE AND FOR SOCIETIES OF APOSTOLIC LIFE, "Rescript Regarding Leasing," in *Roman Replies and CLSA Advisory Opinions 1992*. Washington, DC, Canon Law Society of America, 1992, pp. 15-16.

⁸³ MORRISEY, "The Alienation of Temporal Goods," on p. 311 states: "These acts would be subject to the prescriptions of canon 1295 because, in one way or another, they risk jeopardizing the stable patrimony of the juridical person. Three elements usually enter into account when determining whether there is a risk of jeopardy: (a) loss or diminishing of *ownership*; (b) loss or diminishing of *sponsorship*, and (c) loss or diminishing of *control*." HITE, "The Temporal Goods of the Church," on p. 414 states that "examples of transactions considered as alienation would include: sale or transfer of property; spending fixed or stable patrimony; leasing of property as determined by the Episcopal Conference; changing organizational structure so the juridic person can no longer exercise its canonical obligation; borrowing money; issuing bonds; obtaining a mortgage when church property is used as security and, the transfer of property from a diocese to a religious institute. Examples of transactions not considered an act of alienation include: spending free capital (funds not immobilized); separately incorporating or reincorporating within the same juridic person; receiving mortgaged property as a gift; sale of land and buildings and use of the proceeds for a similar purpose; use of free capital as loan collateral and, replacement of furniture or equipment." See also BOUSCAREN et al., *Canon Law: A Text and Commentary*, pp. 838-839.

⁸⁴ *CIC 1983*, c. 1292, §1: "Salvo praescripto can. 638, §3, cum valor bonorum, quorum alienatio proponitur, continetur intra summam minimam et summam maximam ab Episcoporum conferentia pro sua cuiusque regione definiendas, auctoritas competens, si agatur de personis iuridicis Episcopo dioecesano non subiectis, propriis determinatur statutis; secus, auctoritas competens est Episcopus dioecesanus cum consensu consilii a rebus oeconomicis et collegii consultorum necnon eorum quorum interest. Eorundem quoque consensu eget ipse Episcopus dioecesanus ad bona dioecesis alienanda."

minimum no permission would be required; above the maximum, the permission of the Holy See is to be sought.⁸⁵

Canon 1295⁸⁶ specifies that the norms of cc. 1291-1294 are to be observed in any dealings in which the patrimonial condition of the juridical person may be jeopardized: borrowing money; taking out mortgages; entering into long-term leases; change of status in ownership. F. Morrissey states that these acts are subject to the prescriptions of the canon because, in one way or another, they risk jeopardizing the stable patrimony of the juridical person. Three elements usually enter into account when determining whether there is a risk of jeopardy: (a) loss or diminishing of ownership; (b) loss or diminishing of sponsorship; (c) loss or diminishing of control.⁸⁷

The concept of "ownership" is relatively clear in canonical literature; likewise, to some extent for "sponsorship". But, how does one comprehend the notion of control? Those institutions, civilly incorporated, would be wise to determine exactly those things to be reserved to the sponsoring

⁸⁵ *CIC 1983*, c. 1292, §2: "Si tamen agatur de rebus quarum valor summam maximam excedit, vel de rebus ex voto Ecclesiae donatis, vel de rebus pretiosis artis vel historiae causa, ad validitatem alienationis requiritur insuper licentia Sanctae Sedis." See also *CIC 1983*, c. 638, §§ 1,2; HESTON, *The Alienation of Church Property in the United States*, on p. 87 points out that "this necessity of obtaining authorization from a lawful superior does not interfere with or diminish the property or diminish rights of the owner or owners. This authorization does not confer the power to alienate, since this power is inherent in the very fact of ownership, but rather approves and authorizes the use of that power in a given instance. The need of this authorization is based on the provision of c. 100§3, which considers ecclesiastical juristic persons as minors."

⁸⁶ *CIC 1983*, c. 1295: "Requisita ad normam cann. 1291-1294, quibus etiam statuta personarum iuridicarum conformanda sunt, servari debent non solum in alienatione, sed etiam in quolibet negotio, quo condicio patrimonialis personae iuridicae peior fieri possit."

⁸⁷ MORRISSEY, "The Alienation of Temporal Goods," p. 311. See also HESTON, *The Alienation of Church Property in the United States*, pp. 83-84.

religious institute in order to retain the Catholicity of a hospital, university, institution, etc. The following points should be kept in mind:

- (a) limit corporate membership to persons who are canonical stewards (for instance the major superior and council);
- (b) place corporate membership above the board of directors (trustees);
- (c) determine which powers allow the members to carry out their faith and governance responsibilities.⁸⁸

Concerning the 'reserved powers', the following could be listed:

- 1) to establish or change the philosophy of the corporation (for instance, compliance with the medical-moral code approved by the Conference of Bishops);
- 2) to amend the corporate charter and by-laws;
- 3) to appoint the board of directors (trustees) of the corporation or of intermediate boards, or at least to appoint the chief executive officer and to remove these persons from office;

⁸⁸ MORRISEY, "The Alienation of Temporal Goods," p. 312.

4) to lease,⁸⁹ sell, or encumber corporate real estate (for instance, by contracting debts);

5) to merge, dissolve the corporation, distribute corporate assets.

Other powers which could be reserved are:

6) to approve capital or operating budgets, or both;

7) to require a certified audit or to appoint the certified public accountant, or both.⁹⁰

As a rule of thumb, in any reorganization or restructuring of an apostolate, if the overall canonical control is maintained, there has not been an alienation or a jeopardizing of the stable patrimony.⁹¹ Despite all the precautions taken to ensure that ecclesiastical goods are safeguarded, it sometimes happens that the canon law requirements for alienation are not observed. The civil law requirements are followed, but canonically, the action is not valid. Canon 1296 addresses this

⁸⁹ Concerning the leasing of ecclesiastical property, HESTON, *The Alienation of Church Property in the United States*, states on p. 185 that: "a lease implies a more far-reaching hold on church property than mere rental. It usually confers on the lessee the practical equivalent of property rights without any actual transfer of direct ownership. Leases likewise generally extend over a much longer period of time than ordinary contracts of rental." CLEARY, *Canonical Limitations on the Alienation of Church Property*, states on p. 95 that "the leasing or letting out of things envisioned by the Code, is that contract by which one of the parties obligates himself to grant to the other party the enjoyment of a thing during a certain definite time for an agreed price which the latter in turn obligates himself to pay." According to H. BLACK, *Black's Law Dictionary*, 6th ed., St. Paul, MN, West Publishing Co., 1994, p. 889, a lease is defined as "a contract by which one owning such property grants to another the right to possess, use and enjoy it for specified period of time in exchange for periodic payment of a stipulated price, referred to as rent."

⁹⁰ MORRISEY, "The Alienation of Temporal Goods," pp. 312-313. Cf. MAIDA and CAFARDI, *Church Property*, pp. 157-162.

⁹¹ MORRISEY, "The Alienation of Temporal Goods," p. 313.

situation, requiring that the competent authority carefully weigh all the circumstances and decide what action if any is to be followed in order to vindicate the rights of the Church.⁹²

The canons on ecclesiastical goods and ownership are essential in determining the canonical status of a public juridic person, such as a health care facility. The principal objective of these canons is to safeguard the stable patrimony of the Church.

III. CATHOLIC IDENTITY OF A HEALTH CARE FACILITY

As seen in Chapter One, Catholic involvement in the delivery of health care has a long and distinguished history in Canada, and in particular in New Brunswick. Religious institutes have played a significant and influential role in shaping the modern day health care system. This third section of Chapter Two will examine the third factor in determining the canonical status of health care facilities in New Brunswick — that of Catholic identity.

Webster's Dictionary defines identity as "the state or fact of being a specific person or thing." Just as the individual natural person experiences various phases or cycles in the life process — moments of growth, stability, change and challenges, as well as moments of uncertainty and crisis

⁹² *CIC 1983*, c. 1296: "Si quando bona ecclesiastica sine debitis quidem sollemnitatibus canonicis alienata fuerat, sed alienatio sit civiliter valida, auctoritatis competentis est decernere, omnibus mature perpensis, an et qualis actio, personalis scilicet vel realis, a quonam et contra quemnam instituenda sit ad Ecclesiae iura vindicanda."

in identity — so too institutions face similar experiences, especially in terms of their character, goals and purposes.

Today, institutions are challenged to address some critical issues and thought-provoking questions — who are they, what is their purpose, why do they exist, how do they operate? These are not simple, straightforward questions, hence, there are no simple, straightforward answers.

A. Canonical Sources and Catholic Identity

Identity has as much to do with groups, institutions and organizations as it does with the individual person. The canonical norm determining the individual's identity and membership in the Church is found at c. 96.⁹³

The Catholic Health Association of the United States in its 1993 study of Catholic identity of the health care facility states that the revised Code of Canon Law provides criteria for determining catholicity. The matter is indeed complex, for many institutions and organizations exist within the Church; and these same institutions and organizations relate to the Church and to Church authority in different ways. In each particular Church there can and do exist institutions, each with its own

⁹³ *CIC 1983*, c. 96: "Baptismo in Ecclesiam Christi incorporatur et in eadem constituitur persona, cum officiis et iuribus quae christianis, attenda quidem eorum condicione, sunt propria, quatenus in ecclesiastica sunt communione et nisi obstet lata legitime sanctio."

identity, its own reason for existing and its own purposes. These could include: public and private associations of the faithful; institutes of consecrated life; societies of apostolic life; educational institutions, seminaries, shrines, cemeteries and health care facilities.⁹⁴

Many of these institutions and organizations identify themselves as being Catholic and, although from all appearances that is what they are perceived as, canonically they may not be so. Officially, some of these associations are not recognized by the competent ecclesiastical authority as stated in c. 300:

No association may call itself 'Catholic' except with the consent of the competent ecclesiastical authority, in accordance with c. 312.

Nevertheless, Catholics belonging to unrecognized associations or institutions are subject as individuals to the vigilance and governance of the proper ecclesiastical authority.

B. The Catholic Health Care Facility

What is a Catholic health care facility? What purpose does it have? What characteristics are associated with it? The Catholic Health Association of the United States responds to this question by stating : a Catholic health care facility is one "that people perceive as connected or associated with

⁹⁴ THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES (=CHA), *The Search for Identity: Canonical Sponsorship of Catholic Health Care (= The Search for Identity)*. St. Louis, MO, The Catholic Health Association of the United States, 1994, pp. 20-21.

the Catholic Church.”⁹⁵ The Catholic Health Association of Canada in its *Health Care Ethics Guide* gives more substance in defining the Catholic health care facility. It states:

Catholic health care institutions are communities of service, united through collaborative activities and inspired by Roman Catholic moral principles, for the purpose of promoting a healthy society.⁹⁶

The CHAC continues to develop its understanding of the Catholic health care facility by stressing the importance of a mission statement. Each facility is to develop its own, keeping in mind the recommendations found in the Ethics Guide. The guide states:

Every Catholic health care institution, in its mission statement, proclaims its religious identity that reflects a vision of life and the world that is reasonable and in accordance with the Roman Catholic tradition. It commits itself to provide health care that is holistic and non-discriminatory. This mission will be kept in mind constantly if it is articulate clearly and reviewed regularly, with an opportunity provided for input from all members of the institution.⁹⁷

One of the purposes for the Church’s involvement in health care as well as in other apostolates is the better ordering of human society.⁹⁸ The Catholic health care facility must be more than just a place to take care of sick individuals. It is called to be a place where those afflicted with illness and

⁹⁵ CHA, *The Search for Identity*, p. 21.

⁹⁶ CHAC, *Health Care Ethics Guide*, p. 21.

⁹⁷ Ibid.

⁹⁸ CONSOLIDATED CATHOLIC HEALTH CARE (= CCHC), *Critical Choices: Catholic Health Care in the Midst of Transformation* (= *Critical Choices*). Oak Brook, IL, Consolidated Catholic Health Care, 1993, p. 24.

suffering can encounter the saving Lord and grow in him. This facility must offer a precise and clear invitation to growth and intimacy in the Lord within the context of human sickness.⁹⁹ The CHAC speaks of the purpose of the Catholic health care facility as follows:

Whatever its particular objectives, every Catholic health care institution aims primarily at the relief of suffering and the promotion of health. This leads to policies and programs that emphasize the care of people with acute or chronic illnesses, the prevention of disease and the promotion of health. Such a perspective on health care, that includes promoting a healthy, social and physical environment, demands collaboration among health care institutions and interactions between the health care system and other systems in society: education, housing, employment, religious bodies, professional organizations and unions.¹⁰⁰

In addition to its meaning and purpose, the Catholic health care facility should be endowed with characteristics “that promote healing and possess a spirit of compassion that is rooted in human solidarity and in fidelity to the healing mission of Christ. All persons within the institution are called to create an environment that is marked by mutual respect and sensitivity to the varied needs and concerns of others.”¹⁰¹

J. Rouleau, in his sociological study on the Catholic hospitals in Canada, noted what he considered to be characteristics of a Catholic hospital. These would apply to any health care facility

⁹⁹ D. PILARCZYK, “The Catholic Health Facility: Would You Know One If You Saw One?” in *Hospital Progress*, 63 (1982) 8, p. 31.

¹⁰⁰ CHAC, *Health Care Ethics Guide*, p. 21.

¹⁰¹ *Ibid.*

owned or sponsored by the Catholic Church and are helpful in the study of the identity of these institutions:

- 1) An institution where the majority of patients and personnel are Catholic; religious present in the facility as well as a chaplain;
- 2) a building and part of its equipment are owned by a religious community; a place where one finds a chapel, crucifixes, religious pictures, etc.;
- 3) the institution is governed by a charter, rules and regulations inspired by a philosophy based on the gospel;
- 4) the Catholic Code of Ethics used for fixing guidelines for certain medical procedures — respect for life;
- 5) the organizational chart of Catholic health care facility includes a pastoral or chaplaincy service;
- 6) it is a treatment centre where personal and spiritual needs are given special attention and where pastoral and apostolic activities take place;
- 7) it is an establishment attesting to the presence of the Church in a pluralistic milieu;
- 8) affiliated with the Catholic Health Association of Canada;
- 9) recognized by the bishop;
- 10) a possible alternative to public institutions in the network of health services in a region or a province.¹⁰²

¹⁰² J. ROULEAU, *Present Situation and Future of Catholic Hospitals in Canada*. trans. By E. McCABE, Quebec, Laval University, 1972, p. 38. The author presents a three volume sociological research project undertaken to investigate Catholic hospitals in Canada in the early 1970s. Through the use of surveys and the gathering and compilation of significant data, Rouleau puts forth the current trends of the time regarding health care delivery in a Catholic hospital. The work concludes with an examination of future directions and a series of recommendations.

Although the Catholic Church is the largest provider of health care in the world,¹⁰³ the 1983 Code of Canon Law does not treat health care facilities in the same way it does educational institutions. However, canon law does provide norms thereby protecting their Catholicity¹⁰⁴ J. Provost¹⁰⁵ examines the Apostolic Constitution, *Ex corde Ecclesiae*¹⁰⁶ and the criteria to be used in determining the Catholicity of an educational facility. These could easily be applied with the necessary adaptations to a health care facility. The five criteria are:

- 1) primacy given to every Christian's call to holiness;
- 2) responsibility to profess the Catholic faith;
- 3) witness to a strong and authentic communion with the pope and local bishop;
- 4) conformity and participation in the Church's apostolic goals, and
- 5) commitment to a presence in human society.¹⁰⁷

¹⁰³ J. CASSIDY, "Catholic Hospitals in the World," in *Dolentium hominum*, 14 (1990) 2, p. 22.

¹⁰⁴ J. MYERS, "Canon Law Outlines Obligations of Institutes, Health Facilities," in *Health Progress*, 68 (1987) 3, pp. 88-89.

¹⁰⁵ J. PROVOST, "Approaches to Catholic Identity in Church Law," in *Concilium*, 5 (1994), pp. 15-25.

¹⁰⁶ JOHN PAUL II, Apostolic Constitution, *Ex corde Ecclesiae*, 25 September 1990, in *Acta Apostolicae Sedis* (= *AAS*), 82 (1990), pp. 1475 - 1504. English translation in *Origins*, 20 (1990-1991), pp. 265, 267-276.

¹⁰⁷ PROVOST, "Approaches to Catholic Identity," p. 22. Cf. JOHN PAUL II, Apostolic Exhortation, *Christifideles laici*, 30 December 1988, in *AAS*, 81 (1989), n. 30, p. 519. English translation in *Origins*, 18 (1988-1989), n. 30, p. 575.

Following along the same lines, L. Örsy lists five examples of models useful in examining organizations identified with the Catholic Church. The Catholic Health Association of the United States has adapted them somewhat. They are as follows:

- 1) A health care facility established and owned by a secular authority but operated by the Church or some juridic person within the Church, such as a religious order. Canon law would not be directly enforceable here and as such, the facility would not have to conform to the moral code of the Catholic Church, unless agreements and arrangements were clearly understood and formalized in a written contract.
- 2) A health care facility established and owned by the secular authority with a Catholic unit attached to it. The facility as a whole would not be Catholic, only the unit attached. Again, any agreements made between the facility and the Catholic unit should be clearly spelled out and be contained in some written document, stipulating exactly what is agreed upon regarding Catholicity.
- 3) A health care facility founded under Catholic auspices but possessing no legal connection to the Church as such. Catholicity would be maintained by those who control the facility. Canon law would not govern such a facility, although individual Catholics would be subject to certain provisions, e.g., they need bishop's permission to call the facility 'Catholic.'
- 4) A health care facility established according to Catholic values, principles, and moral standards inserted into the civil charter. A facility of this nature would have no juridic connection to the Church, hence, canon law would not be applicable. However, individual Catholics are subject to provisions of ecclesiastical law. Furthermore, if the facility were to use the name 'Catholic', the bishop's permission must be sought.

5) A health care facility established by the Church or some other public juridic person. According to canon law, this type of facility would have rights and obligations, i.e., would have standing in ecclesiastical courts, and it would come under ecclesiastical authority. Moreover, the goods of such a facility would be classified as ecclesiastical goods. A facility under this classification would operate in the name of the Church and would need permission to use the word 'Catholic' in its title.¹⁰⁸

C. Identity Based on Values

The word "value" can be defined as that quality of a thing which makes it more or less desirable, useful; or it can be a set of beliefs or standards. There appear to be at least six values associated with Catholic identity and the health care apostolate.

To begin, it must be recognized that health care first and foremost is a ministry, a work based on the teachings of the gospel. Its *raison d'être* flows from the mission and example of Christ Jesus who healed the sick and suffering. The Church from its very beginning has sought to imitate its Master and provide care and compassion to those afflicted with illness. Though it is only right and

¹⁰⁸ L. ÖRSY, *The Church: Learning and Teaching: Magisterium, Assent, Dissent, Academic Freedom*, Wilmington, M. Glazier, 1987, pp. 113-119. See also CHA, *The Search For Identity*, pp. 23-24. S See also CATHOLIC HEALTH ASSOCIATION OF ONTARIO, *Sponsorship of Catholic Health Institutions*, Toronto, Catholic Health Association of Ontario Press, 1990, pp. 38-55. J. MURPHY, *The Governance of Church Institutions and Protection of Catholic Identity with Particular Reference to Ontario, Canada*, JCD dissertation, Romae, Pontificia Universitas Lateranense, 1994, p. 83.

proper that the delivery of health care be efficient, effective and financially sound, the bottom line remains that health care is a ministry.¹⁰⁹

The second value that needs to be recognized and upheld is the fact that health care is a ministry to the community. The Church's involvement in health care is not to serve itself; rather, it is called to reach out and respond to the needs of those vulnerable members of society afflicted with sickness. It is of the utmost importance that health care in the Church's perspective attempt to address what is best for the community and how these needs can be properly met. Collaboration and partnership rather than competition, influence rather than control, are essential in modern day health care. This needs to be evident in all spheres of the health care delivery field.¹¹⁰

The third value entailed in Catholic health care is the ministry to the individual, serving the needs of all who come seeking healing, compassion and support. The goal of this care is holistic, thus, caring for the physical, psychological, social and spiritual needs of the human person. It is the whole human person that needs to be cared for, not just the diseased part of that person.¹¹¹

The fourth value to be recognized is that Catholic health care is a ministry to the employees. Those employed in caring for the sick in all dimensions must be given a sense of respect and dignity. The work environment must promote trust, cooperation, participation and innovation, encouraging

¹⁰⁹ CCHC, *Critical Choices*, p. 28.

¹¹⁰ *Ibid.*, pp. 28-29.

¹¹¹ *Ibid.*, p. 29.

all to realize and develop their full potential. They must have a voice in that which affects them and their work. They must be treated fairly and justly in all areas associated with employment. They need to be seen as partners, collaborators in carrying out this mission of the Church in providing care to the sick.¹¹²

A fifth value that needs to be recognized is the fact that Catholic health care is a ministry promoting and protecting life in all its stages. It must recognize the patients' right and responsibility to be informed about their illness and to be assisted in making guided and informed decisions about the types of care available to them. Catholic health care needs to be concerned with helping the patients in their suffering and ensuring they are not overwhelmed by pain. Obviously, assisted suicide is strongly opposed in the Catholic health care facility. The patient is to be assisted in every possible way to cope with and make sense out of the pain and suffering. Furthermore, Catholic health care understands the sorrow and grief and all the other human emotions associated with death. However, it proclaims that death is a natural part of life, it does not mark the end nor the defeat of life.¹¹³

Finally, Catholic health care is a ministry that respects the earth. It acknowledges that it is called to be a steward of the earth, recognizing that resources are indeed limited and committing itself to the use of these resources in an equitable and ecological way.¹¹⁴

¹¹² CCHC. *Critical Choices*. p. 29,

¹¹³ Ibid.

¹¹⁴ Ibid.

D. Determining the Catholic Identity of an Institution

The 1983 Code of Canon Law does not define nor does it provide specific criteria in the determination of the catholicity of an institution. This could be considered a *lacuna*¹¹⁵ in the law, thereby giving flexibility in further examining the notion of catholic identity. Many authors have written on the topic, thus providing insights into this matter. F. Morrissey has done extensive work in this regard and he states that there are basically five approaches which could be used to determine the catholicity of an institution. He calls them (1) the institutional or hierarchical approach, (2) the doctrinal approach, (3) a mixture of the two, as found in the Apostolic Constitution *Ex corde Ecclesiae*, (4) an approach based on values and, finally, (5) an approach based on multiple factors relating to mission.¹¹⁶ A brief examination of these is now in order.

1. The Institutional Approach

The hierarchical or institutional approach in determining catholicity is definitely a legal approach. It provides a clear and precise manner of establishing the lines of authority and

¹¹⁵ CIC 1983, c. 19: "Si certa de re desit expressum legis sive universalis sive particularis praescriptum aut consuetudo, causa, nisi sit poenalis, dirimenda est attentis legibus latis in similibus, generalibus iuris principiis cum aequitate canonica servatis, iurisprudencia et praxi Curiae Romanae, communi constantique doctorum sententia."

¹¹⁶ What follows is taken from F. MORRISSEY, "Catholic Identity of Health Care Institutions in a Time of Change," in R. TORFS (ed.), *A Swing of the Pendulum: Canon Law in Modern Society*. Leuven, Katholieke Universitat Leuven, Uitgeverij Peeters, 1996, pp. 50-58.

responsibility in the Church. The bottom line in this approach lies in the fact that no institution or organization may call itself a Catholic entity without the permission of the diocesan Bishop. Canon 300 states:

No association may call itself 'Catholic' except with the consent of the competent ecclesiastical authority in accordance with c. 312.

Within this particular approach, eleven guiding principles could be stressed. They are as follows:

- (1) The institution would operate under the control of a public juridic person.¹¹⁷
- (2) The institution or work should have some sort of written document to provide proof of its catholicity.
- (3) The principles of Catholic teaching and doctrine would permeate the work of the institution.¹¹⁸
- (4) Those involved in the work of the institution should be known for their uprightness of life.
- (5) The work should operate under the authority of the Church.¹¹⁹

¹¹⁷ *CIC 1983*, c. 803, §1: "Schola catholica ea intellegitur quam auctoritas ecclesiastica competens aut persona iuridica ecclesiastica publica moderatur, aut auctoritas ecclesiastica documento scripto uti talem agnoscit."

¹¹⁸ *CIC 1983*, c. 803, §2: "Institutio et educatio in schola catholica principiis doctrinae catholicae nitatur oportet, magistri recta doctrina et vitae probitate praestent."

¹¹⁹ *CIC 1983*, c. 804, §1: "Ecclesiae auctoritati subicitur institutio et educatio religiosa catholica quae in quibuslibet scholis impertitur aut variis communicationis socialis instrumentis procuratur; Episcoporum conferentiae est de hoc actionis campo normas generales edicere, atque Episcopi dioecesani est eundem ordinare et in eum invigilare."

- (6) The diocesan Bishop would have the right of intervention in an institution and could even ask that certain individuals be removed under defined conditions.¹²⁰
- (7) The diocesan Bishop would possess the right of visitation.¹²¹
- (8) Even though an institution is under the direction of a religious institute, the diocesan bishop would have the right to issue general directions. He would also possess the right to appoint the chaplain.
- (9) A certain quality would be attached to the work of a Catholic institution in terms of providing quality education, quality health care, etc.¹²²
- (10) If the work is classified as a public juridic person,¹²³ then the norms for the administration of temporal goods would be applicable.¹²⁴
- (11) The work engaged by the institution must serve a useful purpose.

¹²⁰ *CIC 1983*, c. 805: "Loci Ordinatio pro sua dioecesi ius est nominandi aut approbandi magistros religionis, itemque, si religionis morumve ratio id requirat, amovendi aut exigendi ut amoveantur."

¹²¹ *CIC 1983*, c. 806, §1: "Episcopo dioecesano competit ius invigilandi et invisendi scholas catholicas in suo territorio sitas, eas etiam quae ab institutorum religiosorum sodalibus conditae sint aut dirigantur; eidem competit praescripta edere quae ad generalem attinent ordinationem scholarum catholicarum: quae praescripta valent de scholis quoque quae ab iisdem sodalibus diriguntur, salva quidem eorum quoad internum earum scholarum moderamen autonomia."

¹²² *CIC 1983*, c. 806, §2: "Curent scholarum catholicarum Moderatores, advigilante loci Ordinario, ut institutio quae in iisdem traditur pari saltem gradu ac in aliis scholis regionis, ratione scientifica sit praestans."

¹²³ *CIC 1983*, c. 1256: "Dominium bonorum, sub suprema auctoritate Romani Pontificis, ad eam pertinet iuridicam personam quae eadem bona legitime acquisiverit."

¹²⁴ *CIC 1983*, cc. 1273 - 1289.

At times, the Church insisted that institutions, such as educational and health care facilities, be established in parishes. Today the difficult question being raised, especially in the face of so many cut-backs and reorganization of social institutions, is whether there really is a need for duplication of services and facilities. This is definitely causing friction in many circles. Therefore, what are needed besides the legal approach just examined are other criteria in order to determine Catholic identity.¹²⁵

2. The Communio Approach

The “communio” approach stems from A. Dulles’¹²⁶ model of the church as a community of the faithful and it allows for a greater degree of participation by all members of the Church. It belongs to the pastors to determine exactly what criteria are needed in determining the ecclesial nature of the works engaged in by an institution or association. The basic principle of the communio approach lies in the building up of the Church, the Body of Christ.

¹²⁵ See A. DULLES, *Models of the Church*. New York, Doubleday and Co., 1987, pp. 34-46.

¹²⁶ *Ibid.*, pp. 47-62.

3. A Mixed Approach

The third approach taken in determining Catholic identity comes in part from the Apostolic Constitution, *Ex corde Ecclesiae*. This papal Constitution recognizes the existence of various types of Catholic educational institutions. The principles found in the document could be adapted and applied to any institution or organization seeking to engage in Catholic works. Five possible criteria will be outlined:

- (1) The work must have a genuine apostolic purpose attached to it.
- (2) The results of the work engaged in must be proportionate to the cost.
- (3) The work of the institution must be perceived as being Catholic and this “Catholicity” must permeate the entire institution.
- (4) The work of the institution must be based on Judeo-Christian principles.
- (5) The work must answer a need and make a contribution to the well-being of the community around it.

The criteria presented in this model are less tangible than those used in the institutional approach; however, they contain many possibilities regarding an eventual re-examination of the Catholic identity of institutions.

4. Values Approach

The criteria used in a values approach identify those values to be promoted and safeguarded by persons responsible for the work of a Catholic institution or association.

- (1) The work must deal with a recognized apostolic activity.
- (2) It must adhere to Catholic values and ethics in all its undertakings.
- (3) The institution must be present to those unfortunate members of society afflicted with sickness and suffering, and should at times offer free services to those in need.
- (4) There must be a holistic approach taken toward the human person — body, soul and mind.
- (5) Respect for the human dignity and self-determination of the individual must be present in the Catholic institution.
- (6) There must be present a respect for suffering and emphasis placed on a fuller life beyond sickness, pain and death.
- (7) Health care in the Catholic facility must be seen as a service and not just as a money making activity.

5. Identity Based on Multiple Factors

A fifth approach regarding the identity of a Catholic health care facility could be the combination of four critical themes, namely, mission, sponsorship, holistic care and ethics. These

elements are interconnected and all four taken together need to be kept in mind when using this approach.

a. Mission

The mission of the Catholic health care facility challenges that facility to examine honestly in what its *raison d'être* consists. The foundation of the mission must be firmly rooted in the gospel message which truly aligns itself with sick and suffering humanity. Those involved in the health care apostolate are called upon to make real in tangible ways the compassion and healing presence of God.

The mission of Catholic health care is something to be proud of and all those who come into contact with it must be aware of the underlying values and principles involved in providing quality care. Many of these values and principles are found in the *Health Care Ethics Guide* prepared by the CHAC. The best way to express all of this is by means of the facility's mission statement, found in a prominent place in each Catholic health care facility.

b. Sponsorship and control

The second factor is "sponsorship" and "control." There can be no doubt that the way society views church involvement in the delivery of health care is definitely changing. Once considered an invaluable partner in health care, religious "control" over the health care apostolate is, because of

circumstances, fast giving way to an “influence” approach. Because of more direct governmental involvement combined with economic factors, even the whole area of “influence” is changing at a rapid pace. F. Morrissey states that

traditionally, sponsorship has emphasized a position of corporate strength and independence through ownership and control via reserved powers. Today, as new relations are established with other providers, a presence is required that relies on the ability to influence.¹²⁷

But even then, there are fewer and fewer opportunities to influence. Some day, we might be limited to exercising an “advocacy” role, speaking out for those who are unable to do so for themselves. The role of the sponsor in health care appears more and more to be like that of “a voice crying out in the wilderness,” upholding Catholic values and principles. Taking into consideration the external needs and pressures surrounding the health care facility, flexibility is what is now required if the Church wishes to continue in its vital mission of caring for the sick. In the future, some hard choices will be required, choices ranging from exerting complete control over a health care facility to having a presence through influence. The kinds of structures needed to maintain a viable presence in health care will greatly influence the future involvement of the Church. The structures and models are there, what is needed now calls for vision and solid leadership in order to continue the integral mission of the Church’s involvement in health care.

¹²⁷ MORRISSEY, “Catholic Identity of Health Care Institutions in a Time of Change,” p. 56. Cf. B. DUNN, *Sponsorship of Catholic Institutions. Particularly Health Care Institutions by the Sisters of Providence in the Western United States*, JCD dissertation, Ottawa, ON, Saint Paul University, 1995, pp. 137-155.

c. Holistic Care

The third factor is holistic care. Providing quality health care in the Catholic facility requires promoting the holistic care of the individual. Care and healing of the whole person — physical, emotional and spiritual — should be one of the hallmarks to be found in Catholic health care. Important not only is the individual patient, but also those who are entrusted with that person's well-being, especially family members, friends, and staff.¹²⁸

Canon law addresses this notion of wholeness in two canons, c. 795 and c. 1136, which by analogy can be applied to health care. Canon 795 states:

Education must pay regard to the formation of the whole person, so that all may attain their eternal destiny and at the same time promote the common good of society. Children and young persons are therefore to be cared for in such a way that their physical, moral and intellectual talents develop in a harmonious manner, so that they may attain a greater sense of responsibility and a right use of freedom, and be formed to take an active part in social life.¹²⁹

Further to this, canon 1136 states that

¹²⁸ MORRISEY, "Catholic Identity of Health Care Institutions in a Time of Change," p. 57.

¹²⁹ *CIC 1983*, c. 795: "Cum vera educatio integram persequi debeat personae humanae formationem, spectantem ad finem eius ultimum et simul ad bonum commune societatum, pueri iuvenes ita excolantur ut suas dotes físicas, morales et intellectuales harmonice evolvere valeant, perfectior responsabilitatis sensum libertatisque rectum usum acquirant et ad vitam sociale[m] active participandum conformentur."

parents have the most serious obligation and the primary right to do all in their power to ensure their children's physical, social, cultural, moral and religious upbringing.¹³⁰

The Catholic health care facility needs to stress the importance of holistic care to all concerned. By doing so, health care is further enhanced and the church's mission of caring for the whole human person continues to be fulfilled.

d. Ethics

A fourth element involved in this final approach to Catholic health care concerns ethics. Webster's Dictionary defines ethics as the "discipline dealing with what is good and bad or right and wrong or with moral duty and obligation; a group of moral principles or set of values." Ethics helps put things into perspective in terms of relationships. For the Christian, ethics finds its ultimate meaning from the gospel message.

Catholic identity in terms of the health care facility and ethical behaviour centers itself on three types of ethics. First, social ethics concerns itself with the kinds of relationships involved in the health care apostolate as well as with the protection of rights and responsibilities of all concerned. Second, corporate ethics centers on decisions, policies and structures relating to the health care facility and how these are carried out in the day to day operations of the facility. Third, clinical ethics in the Catholic health care facility involves the upholding of life at all its stages. It delves into the important

¹³⁰ *CIC 1983*, c. 1136: "Parentes officium gravissimum et ius primarium habent proles educationem tum physicam, socialem et culturalem, tum moralem et religiosam pro viribus curandi."

questions raised in the field of genetics, human reproduction, treatment procedures, and research matters.

The elements found in this approach go together. One without the other would only lead to an incomplete presence in terms of Catholic involvement in health care. The Catholic health care apostolate is at the brink of a new age. New challenges, new debates and new issues confront it. However, taking into consideration the above-mentioned material, there should be little to fear even though in some places the very essence of this apostolate of the Church is seriously threatened.

CONCLUSION

This chapter has attempted to address some of the more essential and important canonical concepts in the determination of the canonical status of health care facilities. These concepts revolve around the notion of juridic personality, ecclesiastical property and Catholic identity. By applying each of them to Catholic health care facilities in New Brunswick, the following conclusions can be offered.

- (1) The religious institutes involved in the health care apostolate in New Brunswick have played an active role in the delivery of health care since 1868. Some have existed in other parts of the country from the early days of exploration and settlement, e.g., the Religious Hospitallers of St. Joseph. These institutes are most certainly ecclesiastical institutions and as such have been granted

juridical personality by the law itself. Their existence has been truly necessary and useful in the various apostolates undertaken. Health care facilities owned and administered by religious institutes in the Province of New Brunswick have contributed to the well being of the sick and suffering. They have existed without being granted separate juridic personality. These facilities are attached to the existing ecclesiastical juridic person — Sisters of Charity, Religious Hospitallers of St. Joseph, Les Filles des Jésus and Soeurs de Notre-Dame du Sacré-Coeur. As such, they participate in the juridic personality and nature of that religious institute. In canon law, Catholic health care facilities in New Brunswick have a useful purpose as well as sufficient endowments to sustain this essential work of caring for the sick. By examining the canon law notion of juridic person the following can be concluded: the health care facility, through the juridical personality of the religious institute, act in the name of the Church and represent the Church in an official capacity, and they have the right to acquire, retain, administer and alienate property and goods. As far as juridic personality is concerned, their canonical status remains unchanged.

(2) According to canon law, only the juridic person is capable of owning ecclesiastical property and goods for the reasons found in the law. In this case, the Sisters of Charity, Religious Hospitallers of St. Joseph, Les Filles des Jésus and Soeurs de Notre-Dame du Sacré-Coeur have, by the universal law of the Church and the proper law of their particular institutes, the right to acquire, retain, administer and alienate ecclesiastical property and goods. These goods, i.e., health care facilities, have been acquired through various sources and in legal ways — funds given from the sisters; diocesan contributions of land and money; bequests; fund-raising endeavours; and public grants. Once

acquired, these facilities have been administered in accord with the provisions of canon law found today in cc. 1273-1289. These goods have also been protected by the means available in civil law, namely through incorporation. This method of civil incorporation is well documented in the Province of New Brunswick as a means of further demonstrating that these health care facilities are indeed ecclesiastical entities.

In terms of alienation, strictly speaking the Catholic health care facility or the sponsoring institute has not taken any action by which the right of ownership of ecclesiastical property has been ceded to the government of New Brunswick. Therefore, the canonical status of Catholic health care facilities in New Brunswick as far as alienation is concerned, remains unchanged. However, if we apply a broad interpretation to the concept of alienation, then Catholic health care facilities, in this case, the Catholic hospitals, have definitively been placed in jeopardy by the new provincial legislation found in the 1992 Hospital Act. If we extend the notion of alienation to acts whereby the right of ownership is or could be diminished, restricted or endangered, then the canonical status of the Catholic hospital facilities has undergone a radical change. Though religious institutes involved continue to own the land and buildings, their control and administration of the facilities has been usurped by the provincial government and placed in the hands of regional hospital boards. Furthermore, by entering into lease agreements with the provincial government, the stable patrimony of the Catholic hospital facilities has been jeopardized and endangered.

(3) The third factor in the determination of canonical status of Catholic health care facilities centers around the whole notion of Catholic identity. There can be no denying that the approach based on an institutional model of ecclesiology is the predominant one used to date in the health care facility in New Brunswick. These facilities have operated under the control of the public juridic person known as the religious institute; they have been perceived by all involved as Catholic facilities where the Catholic ethos permeates the facility with the teachings and doctrine of the Catholic Church. They have been declared by the bishops to be Catholic; they have been watched over and cared for by the bishops; and they have chaplains appointed by the bishops to care for the pastoral and spiritual needs of those sick and suffering. Furthermore, these facilities have provided efficient and high quality health care to those who have passed through their doors.

This approach to Catholic identity and canonical status from an institutional perspective has definitively changed. No longer are these facilities identified in terms of legal approaches. Nevertheless, the opportunity now exists in New Brunswick for new models of health care sponsorship/governance which will allow continued involvement in health care and participation of all members of the community. With the agreement entered into between the provincial government and the religious institutes involved in this apostolate, new opportunities are surfacing. The creation of Advisory Committees in each of the facilities owned by a religious institute offers, if such Committees are used appropriately, the mechanism to secure and promote in new ways Catholic identity.

Having completed the study of the canonical issues involved in determining canonical status of the Catholic health care facilities in New Brunswick, attention now shifts in the next chapter to the secular legislation.

CHAPTER THREE

CIVIL LEGISLATION AND CATHOLIC HEALTH CARE FACILITIES IN NEW BRUNSWICK

From the 1860s religious institutes founded, financed, constructed, administered and staffed health care facilities in the Province of New Brunswick. This is especially true of hospitals and nursing homes, which in many localities preceded any involvement by government authorities to provide adequate and quality health care to its citizens. Religious institutes filled a void in the province in regard to care for the sick including not only Catholics, but all in need of compassion and healing. Their apostolate has been based both on the gospel mandate to heal and on the mission, values, philosophy and ethics of the Catholic Church.

The operation of health care facilities constitutes one of the fundamental and essential religious works of charity. Institutes have provided this work of charity in New Brunswick in a manner consistent with the standards required by provincial legislation on health care. However, in March 1992, the provincial minister of Health and Community Services announced a new policy and legislation for health care delivery in New Brunswick. That new plan resulted in the termination of the long tradition of Catholic involvement in the direct delivery of health care. The new Hospital Act¹

¹ S.N.B., *Hospital Act*, 41 ELIZABETH, 1992, c. H-6.1.

prohibited religious institutes and their members from operating their own hospitals and from providing hospital services anywhere in New Brunswick. Chapter Three will examine the Provincial legislation affecting the canonical status of the Catholic health care facility in New Brunswick. Part One will provide a background of various health surveys, commissions, annual reports and recommendations leading up to Bill 23 — *An Act to Amend the Public Hospitals Act*.² In Part Two, the Hospital Act of 1992, which has become known as Bill 64, and its subsequent effect on the Catholic health care facility will be examined. Perhaps the most significant section of the Chapter, Part Three, will deal with the subsequent Letter of Understanding and Agreement reached in 1993 between the New Brunswick Catholic Health Association, the religious institutes involved in the health care apostolate and the provincial government. What ramifications, if any, has this Agreement had on the canonical status of these facilities in New Brunswick?

I. BACKGROUND TO HEALTH REFORM IN NEW BRUNSWICK

A. Health Reports and Various Documents

Various attempts were made throughout the years to reform and realign the delivery of health care services in New Brunswick.³ Provincial department of health authorities and the various religious institutes owning and administering health care facilities attempted to provide quality and efficient

² S.N.B., *An Act to Amend the Public Hospitals Act*, 31 ELIZABETH II, 1992, c. 62.

³ NEW BRUNSWICK HEALTH AND COMMUNITY SERVICE, *Chronological Overview: Health Reform*, New Brunswick, Fredericton, 1994, 13 p.

care to those in their charge. Both groups were involved as partners in providing the necessary care and compassion to those in need. Both groups co-operated through providing resources, finances, staff, etc. Government involvement in health care really didn't begin until the introduction of the National Health Grants in the late 1940s. These grants provided substantial amounts of public money for construction and major renovations of health care facilities in the province and across the land. The Catholic health care facilities were beneficiaries of these grants. At the same time as tremendous improvement was occurring in the physical layout of facilities in the province, a number of studies were undertaken in order to improve the efficiency of delivering adequate health care services.

In 1950, the Health Survey Committee of the Provincial Department of Health commissioned a detailed study of the hospital facilities⁴ to examine the health care needs and the facilities utilized in the province to answer those needs. This led to yet another report in 1951⁵ by the Provincial Department of Health examining the state of the province and its people, of health administration, provision of health services, hospital facilities, medical care facilities in the province, facilities to treat tuberculosis, cancer and mental health, administrative organization, expenditures and, eventually,

⁴ NEW BRUNSWICK DEPARTMENT OF HEALTH, *Province of New Brunswick Report of the Health Survey Committee*, prepared by the Health Survey Committee headed by Neergaard, Agnew and Craig, Hospital Consultants, 1950. This study consisted of ten parts and dealt with an analysis of current hospital facilities, regionalization of services, bed requirements in the province, business administration and finance in the hospital facilities, general administration of hospitals, professional services, small hospitals and their problems, the government and hospitals, some general considerations and finally, recommendations.

⁵ NEW BRUNSWICK DEPARTMENT OF HEALTH, *Province of New Brunswick Report of the Health Survey Committee*, 25 April 1951, 411 p. This report dealt with the health care needs of the citizens of New Brunswick and the most efficient ways of providing resources both in terms of community and government services.

offering recommendations. One of the most significant recommendations to come from this survey, one that would eventually occupy a place of prominence decades later, was the proposed regionalization of the health care system by dividing the province into a series of regions. Five regional health areas, with a large regional hospital, together with satellite hospitals and clinics were envisioned by this particular survey. However, it was eventually tabled by the provincial government. Nevertheless, the initial groundwork was laid for later reforms in the delivery of health care services.

The Department of Health and Social Services in 1954 made further extensions to the New Brunswick Health Survey Report of 1951.⁶ This report updated the findings and information put forward by the previous report. To further enhance government involvement in various social, educational and health care endeavours, a report on the responsibilities of government was tabled in the provincial legislature on March 4, 1965.⁷ The objectives of this White Paper were outlined as follows:

The government believes that the time has arrived when the respective administrative responsibilities and the fiscal capabilities of the federal, provincial and municipal levels of government must be clearly defined.

It is further believed that, as we move into an era of marked economic and industrial expansion, our provincial objectives should be re-defined and a course

⁶ NEW BRUNSWICK DEPARTMENT OF HEALTH, *Extension to 1954 of the New Brunswick Health Survey Report of 1951*, 61 p. A report prepared in order to bring up to date the 1951 Report by the New Brunswick Health Survey Committee. Submitted by J. WHEATLEY, Survey Research Office, Department of Health and Social Services, 1953-1954.

⁷ PROVINCE OF NEW BRUNSWICK, *White Paper on the Responsibilities of Government*, tabled in the Legislative Assembly, Province of New Brunswick, March 4, 1965, 21 p.

charted to ensure that maximum and continuing benefits will be secured for all our people.⁸

The government, in its White Paper, set in motion a reform affecting all facets of life in New Brunswick. This period also marked the beginnings of the so-called transfer payments by the federal government to offset the enormous expenditures in the fields of education, health care, and job creation programs. The White Paper concluded its report by stating that

the Government of New Brunswick is prepared to accept this principle. We are prepared to accept from this point on, the full responsibility for acceptable minimum standards of education, health, welfare, and justice for all New Brunswickers.⁹

One of the most far reaching and significant changes concerning involvement by government in health care delivery was found in *A Programme for Equal Opportunity*.¹⁰ This was the follow up of the earlier recommendations brought forward by the White Paper on Responsibilities of Government. In the announcement concerning equal opportunity and its relationship to health care in New Brunswick, L. Robichaud, premier of the Province, stated:

The government has undertaken an extensive review of the responsibilities of government in New Brunswick — both provincial and municipal levels. Policies to chart a new course for our government institutions have been developed. These policies are:

⁸ PROVINCE OF NEW BRUNSWICK, *White Paper on the Responsibilities of Government*, p. 5.

⁹ *Ibid.*, p. 21.

¹⁰ L. ROBICHAUD, *A Programme for Equal Opportunity*. Fredericton, NB, Province of New Brunswick, The Queen's Printer, 1965, 13 p.

- 1- The Provincial Government maintains that a basic minimum level of service should be made available to all citizens of the Province in education, health, welfare, justice, and local services, regardless of their ability to pay.
- 2- The Provincial Government maintains that every effort should be made to raise the minimum level of services, as economic conditions and revenues permit.
- 3- The Provincial Government should encourage every local community, and voluntary organization, to supplement the basic provincial minimum level of services to the community.
- 4- The Provincial Government maintains that the greatest share of the costs of providing a basic minimum level of service in education, welfare, health, justice, and local services should be borne by the Province.
- 5- The Provincial Government maintains that the tax system used to raise the required revenues should be based on the ability to pay.
- 6- The Provincial Government recognizes the need and agrees to establish the appropriate organizational structures for efficient administration of basic minimum programs.
- 7- The Provincial Government also recognizes the value of strong local government institutions in the maintenance of a democratic society. Therefore it agrees to ensure that local government and voluntary organizations have the opportunity to participate in the administration of the basic minimum program, and particularly in its supplementation, to the extent that this is feasible.¹¹

More specifically in regard to health care in the Province, the Premier stated:

The Government rejects, at this time, a recommendation of the Royal Commission that the hospitals of the Province become provincially owned. The problems with the hospital system which were recognized by the Royal Commission

¹¹ ROBICHAUD, *A Programme for Equal Opportunity*, pp. 5-6.

are to a great extent still present. However, the Government would prefer to work with the hospital boards towards achieving a satisfactory system rather than resort to provincial ownership. To this end, more stringent regulatory controls will be exercised under the present legislation.¹²

Furthermore, the Premier suggested that the province would assume full responsibility for providing public health services, which up until then were administrated and carried out on a municipal level.¹³ Also, the Premier announced that the province would assume the capital costs pertaining to hospital construction.¹⁴ The programme for equal opportunity in New Brunswick witnessed the overhauling of the very fabric of New Brunswick society. The programme was made law and became effective in 1967. The year 1967 also saw other significant changes concerning a number of Catholic hospitals in the province.¹⁵

¹² ROBICHAUD, *A Programme for Equal Opportunity*. pp. 6-7.

¹³ Ibid., p. 7.

¹⁴ Ibid.

¹⁵ On January 1, 1967 the Capital Bank Loan in the amount of \$847,000.00 of St. Joseph's Hospital at Dalhousie, NB, was assumed as a debt and liability of the Minister of Health as a representative of the Crown in the right of the Province.

On January 1, 1967 the debts and liabilities in the amount of \$530,000.00 of Hôtel-Dieu Hospital, Chatham, NB, were assumed as debts and liabilities of the Minister of Health as a representative of the Crown in the right of the Province.

On January 1, 1967 the debts and liabilities of St. Joseph's Hospital at Saint John in the amount of \$1,845,000.00 were assumed as debts and liabilities of the Minister of Health as a representative of the Crown in the right of the Province.

On January 1, 1967 the debts and liabilities of L'Hôpital Stella Maris de Kent at Ste. Anne de Kent in the amount of \$486,729.23 were assumed as debts and liabilities of the Minister of Health as a representative of the Crown in the right of the Province.

Also of note here, the Sisters of Providence who founded the Hôtel-Dieu de l'Assomption in Moncton, NB, in August 1922 transferred ownership and control of their hospital facility in July 1967 to the Province of New Brunswick for \$500,000.00 as well as debts in the amount of \$879,000.00. The name of

Following the introduction and implementation of Equal Opportunity, yet another survey was commissioned in 1970 by the government to study health care facilities in New Brunswick. This became known as the *Llewelyn-Davies Report*.¹⁶ The scope of this study brought forward the suggestion that more integration was needed within the health care system. To accomplish this effectively the report proposed regional development based on five regions, comprising health care facilities at various levels — regional, district, and community. Another factor in the realignment of health care delivery services in the Province was the introduction in 1970 of the Universal Medicare Program.

By 1977 changes began to occur in the whole medicare scheme in terms of reduction in federal government contributions. This forced the provincial government to introduce the much hated hospital-user-fee system. Such a public outcry resulted that its existence was short lived. The Provincial Task Force on New Brunswick Health Care released in 1977 its recommendations on the

the facility also changed at the time to the Dr. Georges Dumont Hospital.

An Order in Council dated December 20, 1972, authorized the transfer of the property and administration of a number of hospital facilities belonging to Les Religieuses Hospitalières de Saint-Joseph: Edmundston, Lamèque and Campbellton. At the Bathurst facility, patients transferred to the Chaleur Hospital. The provincial government wished the Sisters to maintain the administration of the new facility. However, they declined.

¹⁶ NEW BRUNSWICK DEPARTMENT OF HEALTH, *Study of Health Facilities in the Province of New Brunswick*, Fredericton, April 1970, 48 p. The principal conclusion of this report suggested:

- 1- There should preferably be a joint development of the Dr. Georges L. Dumont Hospital and the Moncton Hospital on the Moncton Hospital Site.
- 2- Plans to redevelop the Victoria Public Hospital in Fredericton as a regional hospital should be abandoned, and a new hospital of 560 beds constructed on the Regent Street Site.
- 3- The whole of the services to be provided by the Saint John Regional Hospital should be located on the combined sites of the Saint John General Hospital and St. Joseph's.
- 4- The Edmundston Regional Hospital should be developed on the present Hôtel Dieu St. Joseph site, in the form of an extension to the existing building.

delivery of health care services in the Province.¹⁷ The main proposal from this Task Force was the establishment of six regions with hospitals divided into regional, district and community facilities.

By the end of the 1970s there was no doubt that obvious changes were needed in the health care system in New Brunswick. Health care had fast become a highly sophisticated and technological giant. A definitive overhaul was in order. Of all the studies, surveys, commissions and reports on the status of health care in the Province, the "Selected Health Care Program" was retained and inaugurated in 1989. Known as the McKelvey/Levesque Report,¹⁸ this report laid the foundation work for some significant reforms in the delivery of health care services in New Brunswick. The Commission's broad mandate involved the following:

- 1- Examine the service mandates and management models of specific components of the health care system, and the interrelationship between those components;
- 2- examine utilization of hospital services, medicare and prescription drug programs and the growth rates in these programs and to identify possible options that would allow for better cost containment;
- 3- examine the costs associated with each of the specific components and the current methods of funding and to identify possible options that would allow for better allocation and use of all available resources;

¹⁷ NEW BRUNSWICK DEPARTMENT OF HEALTH, *Report of the Task Force on New Brunswick Health Care to the Minister of Health*, Fredericton, NB, October 14, 1977, 81 p.

¹⁸ E. MCKELVEY, and B. LEVESQUE, *Report of the Commission on Selected Health Care Programs*. Fredericton, NB, Province of New Brunswick, 1989, 131 p.

- 4- assess the level of funding for these programs and make comparisons with other jurisdictions;
- 5- report findings and make recommendations on how health care services can be better structured, organized and distributed in the most efficient and cost effective manner; and
- 6- submit completed report to government within six months.¹⁹

In order to assist the commission in its task, briefs were obtained from various associations involved in the delivery of health care service in the Province. These included professional associations such as the New Brunswick Hospital Association, the New Brunswick Medical Society, the New Brunswick Pharmacists Association and the New Brunswick Nurses Association. Furthermore, submissions were welcomed and received from the general public and other organizations interested in or involved in some way with health care. Interventions included those from the Government of New Brunswick, especially the senior staff of the Department of Health and Social Services²⁰ and the Department of Finance. Finally, the commission heard submissions from leading Canadian analysts and thinkers of the day on the subject of health care.²¹ A brief was submitted on behalf of Catholic health care and the report was eventually received by officials of the Catholic Health Association of Canada for further study.

¹⁹ MCKELVEY/LEVESQUE, *Report of the Commission on Selected Health Care Programs*. p. 1.

²⁰ This government department officially formed on April 1, 1986, by amalgamating the Department of Health and the Department of Social Services.

²¹ MCKELVEY/ LEVESQUE, *Report of the Commission on Selected Health Care Programs*. pp. 2-3.

Once these submissions were gathered together and analysed, the Commission set about its task of collating the results and writing its report. The McKelvey/Levesque Report consists of two parts. Part one examined topics such as the New Brunswick Health Care System in terms of its utilization and expenditure trends; fiscal environment; limitations of the health care delivery system; indications of willingness to adapt to change; role of the physician; the need to shift from in-patient to community-based care. The section concluded by issuing a call for a new vision for health in the Province.

The second part of the report by the Commission on Selected Health Care in New Brunswick consisted of recommendations to improve the over-all organization and administration of the health care system. The commission issued the challenge to re-assess the existing system by pointing to the usage of more hospital beds than necessary and suggested providing elevated secondary services in many locations throughout the Province.²²

The Commission proposed among other things the establishment of the Premier's Council on Health Strategy as well as Area Health Planning Councils. The Premier's Council would oversee the organization and planning of provincial health care needs.²³ Further areas examined by the Task Force in Part Two of its report included the reduction of acute care beds, program evaluation, budgeting

²² MCKELVEY/LEVESQUE, *Report of the Commission on Selected Health Care Programs*. pp. 47-49.

²³ *Ibid.*, pp. 49-51.

in regards to hospitals, medicare, the prescription drug program and future budgeting concerns. Finally, the idea of an innovation fund was put forward by the Commission.

From this study by McKelvey/Levesque, recommendations regarding health care in New Brunswick were submitted to the Provincial Government. These included, among others:

- a) improvements to the organization and administration of the health care system;
- b) health services research to support effective decision making;
- c) determination of appropriate physican manpower targets and distribution;
- d) improvements to and expansion of non-institutional health care services;
- e) measures to eliminate the over-utilization and reduce the cost of drugs;
- f) measures to eliminate over-utilization of hospital facilities and physican services;
- g) measures to reduce the cost of medicare;
- h) relations with other jurisdictions; and,
- i) health promotion and education.²⁴

In terms of health care facilities, especially hospital facilities, the recommendations found in the report by the Commission on Selected Health Care would eventually give impetus to government restructuring of the health care system in 1992.

²⁴ MCKELVEY/LEVESQUE, *Report of the Commission on Selected Health Care Programs*. pp. 117-119.

B A Health and Community Service Plan for New Brunswick.

Prior to the introduction of the Master Plan of 1992 by the Provincial Minister of Health and Community Services, there existed 51 hospital boards in New Brunswick. Of these, seven administered the affairs of the Catholic hospitals in the Province by following the mission, values, philosophy of Catholic health care and the *Health Care Ethics Guide* guide issued by the Catholic Health Association of Canada. The hospitals' respective Act of Incorporation²⁵ (as amplified in the appropriate by-laws), provided that the Board of Directors had a number of duties:

²⁵ Civil society has within its jurisdiction the authority to determine and endow certain groupings of natural persons as legal persons or juridical persons. Like the natural person, these are endowed with certain rights and obligations. In Canada, the most familiar legal person is the corporation which the *Canadian Law Dictionary* on p. 260 defines as "a legal entity distinct from its shareholders or members with liability separate from its shareholders or members vested with the capacity of continuous succession. A body corporate with or without shared capital." Within the spectrum of the corporation, further entities can be found, such as (1) non-profit corporation, (2) the private corporation, and (3) the public (profit) corporation. The non-profit corporation can be defined as "a corporation, no part of the income of which is payable to or otherwise available for the benefit of any proprietor, member or shareholder thereof." [*Canadian Law Dictionary*, p. 260]. The charitable corporation, which applied to the religious institutes owning and administering health care facilities in New Brunswick, is described on p. 176 of the *Canadian Law Dictionary* as "a body constituted exclusively for charitable purposes no part of the income of which is payable to, or is otherwise available for the personal benefit of any proprietor, member or shareholder." Finally, the private corporation can be defined as "a corporation resident in Canada at that time, not a public corporation and not controlled directly or indirectly in any manner whatever by a public corporation." [p. 945]. H. BLACK, *Black's Law Dictionary*, 6th ed., St. Paul, MN, West Publishing Co, 1994, on p. 1228 describes the public corporation as an artificial person (e.g., municipality or government corporation) created for the administration of public affairs. Unlike a private corporation it has no protection against legislative acts altering or even repealing its character. Furthermore, they are instrumentalities created by the state, formed and owned by it in public interest, supported in whole or in part by public funds, and governed by managers deriving their authority from the state. Incorporation may be granted by either federal or provincial government. Those interests operating throughout the country are regulated by federal statutes, while those on a regional or localized level fall under the jurisdiction of provincial legislation. Three ways exist to bring about incorporation: (1) a private bill; (2) the granting of Letters Patent; and (3) written agreement of corporation. Four of the Catholic hospitals in New Brunswick were incorporated by a private bill, while the remaining hospitals were incorporated through Letters Patent.

the affairs of the corporation shall be managed by a Board of Directors consisting of ... mother general, a number of members of the religious institute, a member appointed by city (town), a member of the medical staff of the hospital, appointed by the Medical Advisory Committee of the institution and others.²⁶

Board of Directors may delegate to officers of the corporation such of their powers with respect to the management of the affairs of the corporation as they deem fit.

(a) "Board of Directors may make by-laws respecting the administration and operation of the hospital,

(b) respecting the appointment of the members of the Board of Directors and their terms of office; and

(c) generally respecting the affairs of the corporation."

Furthermore, the duties of the Board of Directors include the making of by-laws, rules and regulations for the administration of the affairs of the hospital; the board was authorized to borrow money; limit or increase the amount to be borrowed; issue debentures and pledge or sell these for such sums as deemed expedient; hypothecate, mortgage or pledge the real or personal property or both including debts, rights, powers, undertakings and franchises of the corporation to secure any such debentures and any money borrowed for the purposes of the corporation.²⁷

Phase One of the proposed scheme of the Minister of Health and Community Services in New

²⁶ S.N.B., 18 ELIZABETH II, May, 15, 1971, c. 89, *An Act to Amend an Act to Incorporate Saint Joseph's Hospital*.

²⁷ S.N.B., 11 ELIZABETH II, March 26, 1964, c. 82, *An Act to Incorporate L'Hôpital Stella-Maris de Kent*.

Brunswick would reorganize this entire system by replacing the existing 51 hospital boards and management committees in hospitals and health service centres by eight regional boards, each governed by a Board of Trustees.²⁸ The owners of the Catholic hospitals and the New Brunswick Catholic Health Association strongly protested this move by the provincial government.

The duties of these newly created Regional Hospital Boards were to be wide-sweeping as outlined in the departmental document. They included:

- organizing resources;
- establishing organizational structures to deliver all approved programs;
- planning, budgeting, managing and reporting of hospital expenditures and other financial issues;

²⁸ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *A Health and Community Services Plan for New Brunswick*, Fredericton, NB, 1992, p. 10. "This would strengthen regional management, enhance administrative capabilities and maximize available services." Under the proposal, the administration of the Catholic hospitals would be modified.

The administration and control of L'Hôpital Stella Maris de Kent turned over to Region 1 Hospital Corporation (Beausejour) [Recognition of linguistic issue in New Brunswick lead to the creation of two separate regional boards for the Greater Moncton area].

The administration and control of St. Joseph's Hospital, Saint John turned over to Region 2 Hospital Corporation (Fundy).

The administration and control of Hôtel-Dieu de Saint Joseph, Perth-Andover turned over to Region 3 Hospital Corporation (Central).

The administration and control of Hôtel-Dieu de St. Joseph, St. Quentin turned over to Region 4 Hospital Corporation (Northwest).

The administration and control of Saint Joseph's Hospital, Dalhousie turned over to Region 5 Hospital Corporation (Restigouche).

The administration and control of L'Hôpital de l'Enfant Jésus, Caraquet turned over to Region 6 Hospital Corporation (Chaleur).

The administration and control of Hôtel Dieu Hospital, Chatham turned over to Region 7 Hospital Corporation, (Miramichi). This facility closed December 15, 1996 and is scheduled to be demolished.

- overseeing the medical credentialling process and approving hospital privileges for physicians within their respective regions on the recommendations of boards or medical advisory committees;
- ensuring that all resources in the facilities are utilized effectively and efficiently;
- ensuring that approved hospital services are delivered following federal and provincial quality and efficiency standards;
- planning and distributing hospital services as established through the Hospital System Master Plan;
- dealing with all day-to-day operational issues in relation to patient-care needs, as well as all issues regarding how, when, and where to deliver services to accommodate those needs;
- establishing the necessary hospital policies and procedures which facilitate the delivery of approved services;
- ensuring, on behalf of the government, that all entrusted buildings, equipment and land used for the purposes for which they were received, are well maintained;
- maintaining on-going working relationship with other related care or service providers, government, and the public they serve.²⁹

Missing from these duties and responsibilities was any reference to the fact that seven of the institutions were Catholic hospitals, owned by religious institutes and not by the province. Also

²⁹ NEW BRUNSWICK DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, *A Health and Community Services Plan for New Brunswick*, p. 12.

excluded was any promise or guarantee regarding representation on the future boards by representatives of the religious institutes. Representation on Boards of Trustees would consist of 12-16 members, chosen by population, with representation from the regions' urban and rural areas. No promise or guarantee was provided in the document for representation on any other basis. The document contained a description of permanent boards to be phased in after two years. Finally, the document provided that each regional board would have a set of by-laws and some appointments to the board would be made in accordance with these by-laws. Approval of these by-laws and appointments would come from the Minister of Health and Community Services. With the implementation of the Regional Hospital Corporation Board, control over what happens at a Catholic hospital facility was removed. At the time, it was the general perception that these Boards would not permit the Catholic facility to operate under their mission and philosophy statement. Also, there existed a feeling that these facilities would lose their Catholic identity and presence in the Province of New Brunswick.

C. Bill 23: An Act to Amend the Public Hospitals Act

On March 26, 1992, Bill 23 *An Act to Amend the Public Hospitals Acts*³⁰ was introduced in the Legislative Assembly of the Province of New Brunswick by the Minister of Health and Community Services. This Bill would become law on April 2, 1992 and have profound effects on the

³⁰ S.N.B., *An Act to Amend the Public Hospitals Act*, 41 ELIZABETH II, 1992, c. 62. First Reading on March 26, 1992. Second Reading on March 27, 1992. Committee on April 1, 1992. Third Reading and Passed on April 2, 1992.

Catholic health care facilities in the Province. The provisions of the government's Bill included the following:

- (1) The Minister of Health and Community Services to assume the control and management of the business and affairs of the bodies corporate (listed) as the business and affairs relate to hospitals and hospital services.**
- (2) All rights, powers, duties and responsibilities, [...] that relate to hospitals and hospital services were transferred to and vested in the Minister of Health and Community Services.**
- (3) The Minister of Health and Community Services, despite anything in any other Act of the Legislature, in regulations under an Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, to constitute a one-person board of each of the hospitals, with the authority to constitute a meeting of the board with respect to matters that relate to hospitals and hospital services.**
- (4) The Minister of Health and Community Services may exercise any and all the rights and powers and may discharge any and all the duties and responsibilities that may be exercised or discharged by the boards (listed) that relate to hospitals and hospital services.**
- (5) The Minister may enter into agreements or arrangements with financial institutions in order to permit and continue the transaction of the financial affairs relating to hospitals and hospital services.**
- (6) Persons who were members of the boards of hospitals on March 31, 1992, not to exercise or discharge any of the rights, powers, duties or responsibilities of members of those boards that relate to hospitals or hospital services.**
- (7) The Minister of Health and Community Services, despite any other Act of the Legislature, any regulations under any Act of the Legislature, any articles of incorporation, letters patent, by-laws or other document or instrument, given the authority to appoint officers of the hospitals, with the rights, powers, duties and responsibilities that relate to hospitals and hospital services.**

- (8) The control and management by the Minister of Health and Community Services of the business and affairs of the hospitals, terminate at the end of June 30, 1992.
- (9) The Lieutenant-Governor in Council given the authority to make regulations respecting matters necessary in connection with the appointment of officers as well as any matter necessary in the control and management by the Minister of the business and affairs of the hospitals and termination of the Minister's role.
- (10) Bill 23 abrogates any right of action against the Minister in respect of anything done, or omitted to be done, under Bill 23 and states it supersedes the Expropriation Act.³¹

D. Reaction to Bill 23

Reaction to Bill 23 was swift in coming from the religious institutes as well as the bishops of the Province. Almost immediately, legal counsel was retained and advice sought on the government's action to proceed with restructuring plans to overhaul New Brunswick's health care system without prior consultation with those involved in the delivery of health care services.³² At a meeting held on March 29, 1992, between representatives of the religious institutes involved and their legal counsels, four decisions were taken:

- (1) that the province's bishops meet with the Premier;

³¹ S.N.B., *Expropriation Act of New Brunswick*, 20 ELIZABETH II, 1973, c. 6.

³² One legal firm PALMER, O'CONNELL, LEGER, RODERICK & GLENNIE represented by F. Leger remarked that "the tabling of Bill 23 swept away months of work and thousands of dollars of expense that was underway concurrently with the drafting of the legislation (obviously, Bill 23 was in the works for some time prior to March 26, 1992, and was very carefully drafted) since many of the hospital boards were reviewing their documents of incorporation and their by-laws in view of regulations under the *Public Hospitals Act* that had been published in April, 1991.

- (2) that a legal review of Bill 23 be sought;
- (3) that the possibility of a contract with the provincial government be drawn up regarding each Catholic hospital and the delivery of services, thus guaranteeing Catholic tradition in health care facilities be upheld; and
- (4) that the question of Catholic representation on the new regional boards be discussed with the Minister of Health and Community Services.³³

Following the meeting, legal counsel met with Bishop J. Edward Troy of Saint John to review the situation and proposed that he arrange a meeting with the New Brunswick bishops and the Premier. A meeting could not, according to the Premier, be arranged on such a short notice. However, Bishop Troy was able to speak at length with the Premier and voice his concerns over the government's health care proposal. F. Leger notes that

Bishop Troy vigorously argued the position of the Catholic hospitals with respect to the proposed legislation but could get nowhere in his attempt to convince the Premier that its passage through the House should be delayed to give those involved an opportunity to consult their legal counsel and assess the implications of the proposed legislation. It is to be regretted that the Premier adopted an inflexible position and would not budge from the position of his government to proceed with the enactment of Bill 23.³⁴

³³ In attendance at this March 29, 1992 meeting were representatives of the Sisters of Charity of the Immaculate Conception, Hospitalieres de Saint-Joseph (Bathurst); La Congregation des Filles de Jésus; Religious Hospitallers of St. Joseph (Chatham); Les Religieuses Notre-Dame du Sacré-Coeur (Dieppe); Franklin Leger of Palmer, O'Connell, Leger, Roderick & Glennie, Barristers and Solicitors; Lorraine Mills of the New Brunswick Catholic Health Association and by telephone Sister Rosemarie Kugel, President of the Religious Hospitallers of St. Joseph Health System and Mr. Michael Carty, the corporation's solicitor.

³⁴ Letter from F. Leger, April 3, 1992, to Sisters of Charity of the Immaculate Conception, p. 4.

During the meeting held on March 29, 1992, the possibility of challenging the validity of the government's legislation proposed by Bill 23 was also discussed. The possibilities included challenging the Bill as being:

- (a) oppressive legislation;
- (b) expropriation or confiscatory legislation;
- (c) violation of constitutional (charter) rights.

Option C appeared to be the most viable of the three presented. However, upon closer examination, it was found that property rights are not protected by the Charter of Rights and Freedoms. However, the question was posed: does Bill 23 violate the freedom of religion and freedom of association sections of the Charter so far as the Catholic hospitals are concerned? A memorandum from M. Carty concluded that

in order to violate freedom of religion protection granted by the Charter, we must establish that the provision of health care is a fundamental part of the Catholic mission, that running a hospital is a legitimate expression of religious freedom that is subject to charter protection.³⁵

This action would entail a detailed examination of the constitutions of the various religious institutes, Acts of Incorporation, Letters Patent, etc. The notion of a court challenge was tabled to a future meeting. Along with the possibility of a court challenge regarding Bill 23, the possible

³⁵ M. Carty's memorandum found on p. 6 of F. Leger's Letter. It could be noted that this approach was eventually adopted in Ontario when religious institutes introduced court challenges against the hospital restructuring orders of the Provincial Government. See, for instance, Ontario Court of Justice (Divisional Court), File 731, 1996.

amendment of Bill 23 was discussed. This amendment would provide that the Minister of Health and Community Services and hospital boards would respect the mission, values, philosophy and ethics of the various individual hospitals³⁶ found in the mission statements and by-laws. Finally, the meeting concluded with the possibility of establishing a separate hospital board made up of the seven Catholic hospitals in New Brunswick. Bill 23 basically paved the way for the introduction of Bill 64 - the Hospital Act.

II. HOSPITAL ACT 1992: BILL 64³⁷

A. The Hospital Act

On March, 25, 1992 with Bill 23, the new government legislation was adopted, thereby effectively terminating the long hands-on involvement by religious institutes in an integral work of the Catholic Church — the caring for the sick. Then, on May 20 of that year, Bill 64, the new Hospital Act was passed. Effective on July 1, 1992, the Act established eight Regional Hospital Corporations to assume the administration of hospitals in the Province of New Brunswick.

³⁶ In F. Leger's Letter of April 3, 1992 (pp. 7-8) he proposes the following: "I offer the following as a first draft of the type of provision I have in mind:

Bill 23, Section 17. 34: " In exercising the rights and powers and discharging the duties and responsibilities conferred by the provisions of Section 17. 33, the Minister and those persons appointed to the boards or joint boards and as officers of the bodies corporate listed in subsection (1) of section 17. 33 shall at all times respect, and be governed by, the philosophy, principles and goals of each of such bodies corporate as expressed in any mission statement of, or otherwise adopted by, any such body corporate."

³⁷ S.N.B., *Hospital Act*, 41 Elizabeth II, 1992, c. H-6.1.

The basic motivation of the government's new legislation was to implement its program entitled *A Health and Community Services Plan for New Brunswick*. By adopting this program throughout the Province, more cost-effective and efficient health care would be available to all citizens. The transferral of administration of hospitals and hospital services in the Province affected some 43 hospitals and clinics. However, the government made no distinction whatsoever between a government-owned hospital and one owned and operated privately. All were on equal footing.

The Hospital Act included powerful provisions in order to achieve the government's initiatives. Many of the ordinary laws of the Province were put aside, thereby curtailing existing rights of New Brunswick citizens, owners of hospital facilities as well as hospital employees. All rights and obligations with respect to hospital facilities owned and operated by religious institutes were transferred to the new Regional Hospital Corporation. No mention was made of any type of contract or agreement.³⁸ The new Hospital Act made provision for the takeover of all property, with the exception of land and buildings. No mention was made of what rightly belonged to religious institutes.

³⁸ S.N.B., *Hospital Act*, Section 3.2: "All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region [...] Hospital Corporation."

The government also assumed for itself, by enacting special regulations, additional powers to seize the religious institute's land and buildings, if such were to be used as a hospital, at any time.

The provisions of the Expropriation Act to safeguard and protect property rights were non-applicable after the introduction of the new Hospital Act. The government simply replaced this Act in regard to hospitals by a phrase stating that any determination of compensation had to be submitted to arbitration.

Under the legislation, religious institutes were forbidden to provide hospital services anywhere in the Province of New Brunswick. Furthermore, they were legislatively prohibited from appealing to the courts for any form of relief from government's actions. As well, employees of hospitals owned by religious institutes were forbidden by the Act to launch a suit for dismissal consequent upon the takeover of the religious institutes' rights and obligations.

In place of the long-standing involvement and operation of religious hospitals in New Brunswick, the Minister of Health and Community Services was given the authority and power to require that the Regional Hospital Corporation enact by-laws. These by-laws were to ensure that the religious institute's mission, values and philosophy in the delivery of health care be preserved. However, this was not enough. The Province of New Brunswick, through the Minister of Health, would essentially take over and replace the Church's work of caring for the sick. Basically, the

government stated that the Catholic Church as such no longer had a place or a role to play in hospitals and hospital services in New Brunswick.

B. Reaction to the Hospital Act

Religious institutes owning and operating the seven Catholic hospitals in New Brunswick along with the bishops, the NBCHA, CHAC and others concerned raised their objections to the new Hospital Act.³⁹ Meetings were hastily arranged and a writing campaign begun in order to challenge the government's legislation.

Basically, the objections raised by the Catholic hospital community revolved around the government's failure to provide sufficient advance notice of its intention to change, in such a dramatic way, the health care system in the Province. Nor was adequate opportunity given for consultation regarding the overall plan of regionalization of hospitals and hospital services. Objections were also raised regarding the government's outdated and "dictatorial"⁴⁰ approach to the whole matter. In seizing ecclesiastical property and threatening religious institutes with public prosecution if they attempted to continue providing hospital care, the government violated one of the essential purposes for the existence of the religious institutes — the health care apostolate.

³⁹ Letters sent to Premier Frank McKenna from Superiors of Religious institutes involved, and bishops. The most vocal was the letter of Bishop J. Edward Troy of the Diocese of Saint John, sent on April 23, 1993.

⁴⁰ Archbishop D. Chiasson, Letter to Premier Frank McKenna, May 21, 1992.

For nearly one year, the religious institutes, the provincial bishops and Catholic Health Association personnel (both nationally and provincially) continued to make their position known regarding the government's legislation. They continued to press for further discussions in the hope of clarifying their role in hospital care and the kinds of provisions government would implement if this apostolic work were to continue. However, the provincial government was firm in its position of adopting the new legislation contained in Bill 64. Control of all hospitals in New Brunswick, regardless of the type, through the regional hospital boards, appeared as the only way to establish a regional and centralized form of hospital administration. In the mind of the government, regional hospital administration was paramount in terms of controlling escalating costs and improving the delivery of health care services through the Province. Over the course of this time span, the religious institutes stated over and over again that they were not opposed to a restructuring of the health care system in New Brunswick. Furthermore, they were not opposed, either, to the idea of a regional form of hospital administration.

During a time of debt reduction and cost-saving measures, reform was necessary and essential but at what price? Was there truly a need to assume absolute control over privately owned hospital facilities in New Brunswick? The owners of the Catholic hospitals in New Brunswick were just as adamant that their right as well as that of all religious denominations to establish and operate hospitals be recognized and protected. Above all, Bill 64's prohibition against religious hospitals had to be removed. Both sides in the matter appeared to be at logger-heads. The provincial government refused

even to discuss the possibility of restoring to the religious institutes the administration and control of the hospitals taken from them in 1992. If this could not be done, somehow, somewhere, negotiations had to achieve some satisfactory settlement in preserving the religious character and values of the Catholic hospitals now administered by the provincial government.

C. Proposal of the New Brunswick Catholic Health Association

On May 7, 1992, the New Brunswick Catholic Health Association brought forward a proposal in the wake of Bill 64. The proposal began by recognizing that health care is an essential apostolate of the Catholic Church and that this apostolate had been exercised in New Brunswick since 1868. Next was stated the commitment of Catholic health care and the desire to continue the partnership and long tradition of the religious institutes in health care in the Province.⁴¹ Following these two sections, the NBCHA brought forth its proposal.

The proposal compared the situation of the Catholic hospitals in New Brunswick to that of

⁴¹ NEW BRUNSWICK CATHOLIC HEALTH ASSOCIATION (= NBCHA), *Proposal of the New Brunswick Catholic Health Association to the Minister of Health and Community Services*, May 7, 1992. It is stated on p. 1 of the proposal: "There is no compromise in terms of quality care offered in Catholic institutions or programs, no question of not respecting the proper use of the health care dollar. Indeed, Catholic hospitals are recognized as leaders in the quality of care and efficiency of operation. Our approach to health care treats the total person as we strive to integrate our values with the physical, psychological, social and spiritual needs of our patients."

the minority language school boards. In restructuring the educational system in the Province, the government recognized the principles of pluralism and subsidiarity in preserving the values and principles associated with minority language schools. After much discussion and deliberation, the *Schools Act of New Brunswick (Bill 11)* was amended in order to establish a separate school board for the express purpose of preserving the culture, values and heritage of minority language groups.

The NBCHA proposed to the government that the same approach was possible to preserve the values, traditions and heritage of the Catholic hospitals in New Brunswick. Furthermore, the NBCHA proposed that the Public Hospitals Act be amended to protect and preserve the mission, values, philosophy and ethics of these institutions. To this end, the Association considered it essential that the owners of the Catholic hospitals continue to appoint a local hospital board which would be responsible to them for maintaining the mission and value system of their hospitals. Consistent with Bill 11 (*An Act to Amend the School Act*), the local community board for Catholic hospitals would:

- (a) be responsible to the Regional Board for the delivery of those health care programs and services approved by the Regional Board or Minister of Health and Community Services;
- (b) have the daily administration, management and supervision of the Catholic hospitals for which it was responsible, subject to the general policies, direction, and authority of the Regional Board;
- (c) undertake, on behalf of the Regional Board, the hiring and immediate supervision of hospital personnel at the hospital for which it is responsible;

(d) generally, perform such other duty or function in relation to the hospital for which it is responsible as may be assigned by the Regional Board;

(e) nominate to the Minister for the appointment to the Regional Board such number of its members to be trustees as prescribed by regulation.

Moreover, the New Brunswick Catholic Health Association sought from the government:

(1) a commitment that the Regional Board respect the mission, values and ethics of the Catholic faith, as outlined in *The Health Care Ethics Guide*, when making operational decisions affecting the Catholic institutions,

(2) while all staff would be employed by the Regional Board, all personnel and medical staff working within the Catholic hospitals, would agree in writing, to abide by the mission, values and ethics of the Catholic institution.

Some of these proposals, would eventually find their way into the 1993 Letter of Understanding and Agreement and be incorporated in the amended Hospital Act. The proposal concluded by presenting Catholic health care as an essential option in the Province. The religious institutes owning hospitals in New Brunswick and the four bishops of the Province stated:

We believe a church-sponsored presence in health care is an option considered to be essential to the pluralistic fabric of our society. We believe Catholic institutions and programs preserve a pattern of values inherent to our Christian tradition. These values

and ethics are an important contribution as an antidote to the depersonalization and dehumanization already affecting the health care system.⁴²

III. SUBSEQUENT LEGISLATION AND AGREEMENT

In 1993, just one year after the implementation of the new Hospital Act, the New Brunswick Catholic Health Association, the religious institutes owning hospital facilities and the provincial government agreed on the terms of a Letter of Understanding.⁴³ This Agreement would be a compromise position on the part of all involved. The Agreement is pivotal in the examination of the canonical status of the Catholic health care facility in New Brunswick for it allows for some degree of participation in the delivery of health care services in the Province. Furthermore, the Agreement provides safeguards so that religious health care facilities can be maintained within the regionalization program of the government. The key instrument in providing these safeguards is the establishment of Advisory Committees at each of the hospital facilities owned by a religious institute. Essential elements found in the Letter of Understanding and Agreement of 1993 consist of the following:

⁴² NBCHA, *Proposal of the New Brunswick Catholic Health Association to the Minister of Health and Community Services*. p. 4.

⁴³ PROVINCE OF NEW BRUNSWICK, *Agreement Between the New Brunswick Catholic Health Association. La Congrégation des Filles de Jésus; Sister[sic] of Charity of the Immaculate Conception; Les Religieuses de Notre Dame du Sacré-Coeur; Religious Hospitallers of St. Joseph; Les Religieuses Hospitalières de Saint-Joseph and the Province of New Brunswick.(= Agreement)*. April 21, 1993, Fredericton, NB, 9 p. This Agreement came about through the efforts of a number of individuals, including legal counsel representing the interests of the owners of Catholic hospitals in New Brunswick, officials from both the New Brunswick Catholic Health Association and the Catholic Health Association of Canada, the General Superiors of the religious institutes engaged in the Catholic health care apostolate in the Province and the New Brunswick Bishops, represented by Most Rev. J. Edward Troy, Bishop of Saint John. See Appendix C, pp.283-340.

- A Letter of Understanding;
- Amendments to the Hospital Act and Hospital Services Regulations;
- Required By-law Wording for Regional Hospital Corporation;
- Job Description of Facility Administrator; and
- Lease for each Catholic Hospital Facility.

An examination of the key parts of the New Brunswick Agreement sheds further light on the model used to preserve participation in the health care delivery system by the religious institutes.

A. Letter of Understanding and Agreement

On April 21, 1993, A Letter of Understanding was signed between the New Brunswick Catholic Health Association, the religious institutes and the Province of New Brunswick. The Letter expressed the desire that the differences caused by the reorganization of the health care system in the Province the previous year could be resolved in an amicable manner. In an attempt to provide safeguards for the preservation of religious health care facilities, the Letter of Understanding put forward the desire that

the mission statements that have been associated, or will be established, with respect to the delivery of services at the religious hospitals will be adhered to and this will be reflected in the Region Hospital Corporation's by-laws. Only services consistent with the above will be provided in the religious hospitals.

However, since the services to be available in each religious hospital will continue to be defined by the Province in the Hospital System Master Plan, as will the number and types of beds, the existing mission statements will be revised, as required,

to remove any references to specific bed numbers and services except as provided for in the Hospital Master Plan.⁴⁴

A second principle the Letter of Understanding wished to make clear revolved around the physical features and characteristics of the religious hospital facility. It was agreed that those features associated with the religious institute owning the facility would remain. Therefore, the facilities' religious name, its religious signs in terms of sacred art, its chapel, would be preserved for as long as the facility continued to be owned by the religious institute, even though the facility would be administered by the government. This could be seen as another guarantee of preserving the Catholic identity of the health care facility in the Province of New Brunswick.⁴⁵

As a result of the termination of the individual hospital boards in the Province and the appointment of a facility administrator — an issue of contention — some degree of participation would be provided for the religious owner of the hospital. The matter of appointment shows the compromise position taken by the parties to the Agreement. This was not the ideal situation but it was better to have a small opportunity than none at all.

Each Order will have the opportunity to provide input directly to the respective Region Board on the selection of the facility administrator in the following manner. The facility administrator of a religious hospital shall be appointed by the Region Board on the recommendation of an interview panel, 50% of the members of which

⁴⁴ PROVINCE OF NEW BRUNSWICK, *Agreement*, paragraph 1. The second part of this paragraph continues by stating that, "Section 47 of Regulation 92-84 under the Hospital Act will be amended to provide that the Minister "shall" require boards of trustees to enact by-laws respecting mission statements."

⁴⁵ *Ibid.*, paragraph 2.

will be appointed by the Advisory Committee and 50%, including the Region C.E.O., appointed by the Region Board.⁴⁶

Furthermore, in another attempt to preserve the identity of the religious health care facility, provisions were set forth that

the facility administrator, region and other staff, and also the medical practitioners who use the religious hospitals, will agree in writing to abide by the mission statement in effect from time to time in the religious hospitals in which they work.⁴⁷

Regarding participation on the Region Hospital Board, something the Hospital Act failed to address the first time round, the Letter of Understanding contains the provision that one of the members of each Region Board in the Province would be a nominee of the religious institute owning a religious hospital facility in that particular region.⁴⁸

While paragraphs 1 and 5 of the Letter of Understanding would be reflected in the Hospital Services Regulation (92-84), paragraph 6 would be implemented by an amendment to the Hospital Act itself. This section of the Letter of Understanding revolved around the matter of the Advisory Committee. The Advisory Committee would become in the Province of New Brunswick the model

⁴⁶ PROVINCE OF NEW BRUNSWICK, *Agreement*, paragraph 3. Under part b of this paragraph it is further stipulated that "the job description of facility administrators of religious hospitals shall be basically the same for all religious hospitals; the region C.E.O.'s, to whom the facility administrators report, shall delegate to the facility administrators the responsibility of operating those hospitals on a day to day basis." This is a very clear example of the erosion of complete control of the hospital facility owned by the religious institutes in the Province of New Brunswick.

⁴⁷ *Ibid.*, paragraph 4.

⁴⁸ *Ibid.*, paragraph 5 states that "One of the members of each Region Board will be a nominee of the Order owning a religious hospital in that region, and this will be reflected in the Regulations and in the by-laws of the Region Hospital Corporations."

of governance, securing and promoting the mission, values, philosophy and ethics of the Catholic health care facility. Under this paragraph, seven matters were addressed pertaining to the Advisory Committee. They are as follows:

- (a) There shall be an Advisory Committee, established pursuant to provisions in the Hospital Act, for each religious hospital. An Advisory Committee shall consist of not more than eight persons appointed by, and reporting to, the respective Orders. The Advisory Committee shall be responsible for the development and revision of the mission statement as it relates to the preservation of the character of each religious hospital. This mission statement shall not be in conflict with the respective region service plan.
- (b) An Advisory Committee shall have the role and responsibility of monitoring the performance of the facility administrator in the operation of the hospital as a religious hospital; an Advisory Committee may make recommendations, through the Region Boards, to require that the Regulations and by-laws relating to a religious hospital be observed.
- (c) An Advisory Committee shall have access to the staff and relevant records of the religious hospital and Region Board in order to carry out its role as observer of the mission.
- (d) An Advisory Committee's role shall encompass the determination of the mission programs and services essential to maintain the character of the religious hospital.
- (e) The Advisory Committee's role shall also encompass monitoring and requiring corrective measures in the subsequent application of the mission programs and services so established.
- (f) Each Advisory Committee will be chaired by a nominee of the respective Order, who will have direct access to the region C.E.O., as required. An honorarium will be provided in regard to this function.

- (g) The Region Hospital Corporation will cover the reasonable costs associated with the Advisory Committees within established government guidelines.⁴⁹

After providing the criteria for the establishment and duties of the Advisory Committee in safeguarding the preservation of the religious identity of the Catholic hospital facility, other matters of importance surrounded the ownership of the facility itself. Thus, leases would be drawn up, governing the use of the religious hospital facility by the Region Hospital Corporation.⁵⁰ However, no mention was made of how this would be reflected or implemented.

The Agreement further stipulated that the Letter of Understanding would remain in effect as long as the religious institutes involved continued to own any part of the hospital facility.⁵¹ Providing this condition remains, the Department of Health and Community Services would provide annual grants to the religious institutes whereby they could continue their membership and be involved in the Catholic Health Association of Canada and the New Brunswick Catholic Health Association.⁵²

⁴⁹ PROVINCE OF NEW BRUNSWICK, *Agreement*, item b-g of paragraph 6 would be reflected in the Hospital Services Regulations 92-84.

⁵⁰ *Ibid.*, paragraph 7 states that: "There will be leases governing the use of the religious hospitals by the Region Hospital Corporation that will run indefinitely. A two year notice of withdrawal by either party will be required."

⁵¹ *Ibid.*, paragraph 8.

⁵² *Ibid.*, paragraph 9.

Paragraph 11 of the Letter of Understanding dealt with the whole question of ownership of the religious hospital facility. As already seen in the previous chapter, ownership has much to do with the determination of canonical status. The parties to the Letter of Understanding agreed that

an independent and mutually acceptable determination of the level of ownership (equity) will be carried out by mutually acceptable professionals, with free access to all necessary documents,

any disagreement, which cannot be resolved, with respect to the process of determining the level of ownership shall result in the application of the arbitration provisions contained in section 32 of the Hospital Act, and

a Region Hospital Corporation, following consultation with the Advisory Committee, will have full authority to undertake any physical modifications required to enable the facility to carry out its assigned functions in an efficient, effective, quality manner, provided such modifications are in accordance with the provisions of a lease of the facility.⁵³

In response to Bill 64's prohibition against religious hospitals in the Province of New Brunswick, the Letter of Understanding clarified the issue by stating that

the Province agrees to amend the Hospital Act to allow a body corporate, including those established and controlled by a religious denomination,

- (a) to establish, operate and maintain a hospital facility in the Province; and
- (b) to operate such facility in accord with the tenets and beliefs of that religious denomination.

⁵³ Regarding the question of equity of the religious hospital facility, to this date nothing has been resolved between the government of New Brunswick and the religious institutes owning hospital facilities in the Province.

The lifting of the prohibition was seen to be essential if any agreement was to be successful. By agreeing to amend the Hospital Act, the Province acknowledged the right of religious institutes to continue their work of charity in caring for the sick.

The remaining paragraphs 13-19 concluded the Letter of Understanding by providing details on the criteria, rules and standards for the operation of the hospital.⁵⁴ Furthermore, a provision is contained in the Letter of Understanding regarding what can and cannot be used as a hospital. In terms of paragraph 16 the stipulation is put forward that facilities owned by a religious institute or other group in the Province would not be entitled to receive provincial government capital grants or operating grants.⁵⁵ Along the same lines, the amendments to the Hospital Act would not jeopardize the government's authority to provide effective and efficient quality health care to the citizens of New Brunswick.

Subsequently, the contents of the Letter of Understanding would be included in a formal agreement binding on all concerned.⁵⁶ In addition, provisions would be included in the Hospital

⁵⁴ PROVINCE OF NEW BRUNSWICK, *Agreement*, paragraph 13 states that "the power to establish such criteria, rules or standards will include the power to regulate aspects of the operation relating to hospital care delivery, admission and discharge, record keeping, medical staff privileges, reporting requirements to the Minister, the right of inspection by the Minister or agent, and in general, other matters relating to hospital care delivery; the power will be limited to criteria, rules and standards consistent with those of general application to other facilities."

⁵⁵ *Ibid.*, paragraph 16 states that "nothing in the amendments to the Hospital Act shall create, or imply, an obligation that facilities operated by bodies corporate established pursuant to those amendments are entitled to receive provincial government capital grants or operating grants."

⁵⁶ *Ibid.*, paragraph 18.

Services Regulations (92-84), further defining the role and power of the Advisory Committee. Finally, provision for the membership of a nominee of the religious institute on each Regional Hospital Corporation Board would be included in the Letter of Understanding.

B. Amendments to the Hospital Act

The second component in the Agreement signed on April 21, 1993 was two Bills to amend the Hospital Act implemented the previous year. Bill 82 incorporated paragraph 12 of the Letter of Understanding allowing a religious group to establish a hospital facility. Section 32.1 of the new Bill states that

a person other than a hospital corporation may establish, operate or maintain a hospital facility in the Province if the Minister has issued to the person a license authorizing the person to establish, operate or maintain a hospital facility.⁵⁷

The section continues by stipulating the conditions under which the license may be granted as well as its renewal, revocation, and reinstatement. The duties of the license are laid down in areas such as maintaining necessary reports on patients, finances and other related matters. Finally, conditions are made for the appointment of inspectors whose purpose would be to inspect a hospital facility on behalf of the government in order to ensure that proper procedures are followed in the delivery of health care services throughout the Province.

⁵⁷ S.N.B., *An Act to Amend the Hospital Act*, 42 ELIZABETH II, 1993, Bill 82, section 32.1.

Bill 83⁵⁸ would implement the establishment of the Advisory Committee dealt with in paragraph 6 of the Letter of Understanding. These Advisory Committees would act as agents safeguarding the mission, values, philosophy and ethics of the Catholic hospital facility in New Brunswick. After section 15 of the Hospital Act of 1992, the amendment reads as follows:

15.1 (1) There shall be an advisory committee for each hospital facility that is owned in whole or in part by a religious order and that is operated by a hospital corporation.

15.1 (2) The members of an advisory committee referred to in subsection (1) shall be appointed by and report to the religious order that owns the hospital facility in whole or in part.

15.1 (3) The purpose of an advisory committee is to ensure the preservation of the religious philosophy, values and mission associated with the hospital facility.

15.1 (4) The advisory committee may

(a) prescribe for the hospital facility a statement respecting the philosophy, values and mission to be associated with the delivery of hospital services at the hospital facility,

(b) determine the mission programs and services essential to fulfill the mission set out in the statement prescribed under paragraph (a),

(c) monitor compliance with the statement prescribed under paragraph (a) and the mission programs and services determined under paragraph (b), and

(d) do such additional things as are prescribed by regulation.

15.1 (5) The philosophy, values and mission set out in a statement prescribed under subsection (4) and the mission programs and services determined under subsection (4) shall not conflict with the parameters established and the direction

⁵⁸ S.N.B., *An Act to Amend the Hospital Act*, 42 ELIZABETH II, 1993, Bill 83.

issued by the Minister in relation to the planning, organization, management and delivery of hospital services by hospital corporations.

15.1 (6) The Minister shall not, in relation to a hospital facility for which there is an advisory committee, approve the delivery of hospital services that conflict with the philosophy, values and mission set out in a statement prescribed under subsection (4).

As late as October 11, 1994 the chairperson of the New Brunswick Catholic Health Association wrote to the Minister of Health and Community Services expressing concern over the intent of section 15.1 (5) and (6) as well as section 32.1 (3) (a) and (b) of the Hospital Act. A response was received from the Minister on April 11, 1995 outlining the government's intention. This Letter of Comfort is now part of the Agreement signed in 1993.⁵⁹

C. Required By-Law Wording for Region Hospital Corporation

The third component of the New Brunswick Agreement contains the required by-law wording of the Region Hospital Corporation pertaining to the Catholic hospital facility in a particular region. Basically, it puts into the proper by-laws of the Region Board⁶⁰ the provision found in section 35 (1)

⁵⁹ See Appendix G, p. 323 for Letter of Comfort from the Minister of Health and Community Services, dated April 11, 1995, stating the government's intention on this section of the amended Hospital Act.

⁶⁰ DEPARTMENT OF HEALTH AND COMMUNITY SERVICES, revised July 4, 1995.

of the Hospital Act and section 47 of the Hospital Services Regulation (92-84) and contained in the Letter of Understanding. The by-law wording states that

The Philosophy Statement and Mission Statement approved by the Advisory Committee shall be adhered to by the Region Hospital Corporation once the Minister and the Congregation have agreed, in writing that they are appropriate.

The name and characteristics of the facility will be preserved, as per the Letter of Understanding and paragraphs 4 and 5 of Schedule C of the lease.

The facility administrator job description for a hospital facility owned by a Catholic Religious Order and managed/operated by a Region Hospital Corporation will be consistent with the version issued by the Department of Health and Community Services and dated January 25, 1994.

The process for selecting a facility administrator outlined in the Letter of Understanding will be adhered to by the Corporation and the Religious Order. Facility staff will agree in writing to abide by the approved Mission Statement, as per the Letter of Understanding.⁶¹

This third component concludes by stressing that the relationship between the Advisory Committee of each religious hospital facility and the Regional Hospital Corporation would be guided by the provisions found in the Letter of Understanding.

⁶¹ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Required By-law Wording for Region Hospital Corporation By-law," see Appendix H, p. 325.

D. General Position Description for Administrator of Catholic Health

Care Facilities

The fourth component in the Agreement centers around the position of facility administrator. The Department of Health and Community Services in its general description of the position for a Catholic hospital facility deals with three areas. First, it gives a summary of the position to be undertaken by stating that “the facility administrator of a Catholic hospital facility shall be responsible for the effective and efficient day-to-day operation of the facility.”⁶² Second, and most important as far as safeguarding the Catholicity of the hospital facility, the facility administrator

shall also be responsible to ensure that the operation of the hospital facility achieves the objectives of the mission statement of the facility developed by the facility’s Advisory Committee and accepted by the Corporation’s Board and complies with the specific provisions of the Hospital Act and Regulations, the Corporation’s By-laws and the Agreement between the Catholic religious Orders and the Province of New Brunswick relating to preservation of the character, values and philosophy of a Catholic religious hospital facility.

The facility administrator shall participate in the organization and direction of the activities and programs of the facility in a manner consistent with the operational policies of the Region Hospital Corporation, its By-laws and Strategic Plan, as well as the New Brunswick Hospital System Master Plan and related parameters and guidelines issued by the Minister of Health and Community Services and all applicable statutes and regulations of New Brunswick and Canada.⁶³

⁶² PROVINCE OF NEW BRUNSWICK, *Agreement*, “General Position Description for Administrators of Catholic Religious Hospitals” (= “Position Description”), see Appendix I, p. 326.

⁶³ *Ibid.*, p. 327.

The second part of the job description points out that the facility administrator has a two-part reporting relationship. The first is to the Regional Hospital Corporation CEO and the second is to the Advisory Committee of the religious hospital facility in terms of

implementation of the mission statement and in compliance with the Hospital Act and Regulations, the By-laws and the Agreement between the Catholic Religious Orders and the Province of New Brunswick as they relate to the preservation of the character, values and philosophy of a Catholic religious hospital facility.⁶⁴

The third part of this component concerning the job description of the administrator highlights the regular duties and responsibilities expected of one appointed to this position. These duties and responsibilities would be those essentially found in any hospital facility in the Province. However, in regard to the Catholic hospital facility the following duties and responsibilities would also be expected of the administrator. They include:

- 1) Maintain an effective working relationship with medical practitioners ensuring that the values, philosophy and mission of the Catholic hospital facility are maintained in policies and procedures.
- 2) Agree in writing and ensure that all Region Hospital Corporation employees, medical practitioners and others providing health care services in the hospital facility, have agreed in writing to abide by the mission statement of the facility in effect from time to time.
- 3) Cooperate with the Advisory Committee in identifying programs and services the Committee considers to be essential to implement the mission statement as it relates to the preservation of the character of the religious hospital and in implementing approved, funded programs and services.

⁶⁴ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Position Description," see Appendix I, p. 327.

- 4) Cooperate in the establishment and implementation of a Pastoral Care Coordination Program to assure that pastoral care services are available to hospital patients.
- 5) Cooperate with the Advisory Committee in providing reasonable access to hospital facility committees, staff and records that directly relate to enabling the Committee to fulfill its role.
- 6) Attend Advisory Committee meetings.
- 7) Demonstrate an interest in professional advancement for self and effectively encourage others toward this goal, e.g. attendance at educational seminars sponsored by a variety of organizations, including the New Brunswick Catholic Health Association and The Catholic Health Association of Canada.
- 8) Familiarize himself/herself with the contents of the following: [...], the Agreement between the Catholic Religious Orders and the Province of New Brunswick, the Catholic Health Care Ethics Guide and the hospital facility's mission statement.⁶⁵

What has been stated in the facility administrator's job description by the Department of Health and Community Services concerning the administrator and included in the Agreement allows for the continuation of the Catholic presence in health care in New Brunswick. Certainly in this regard, the Advisory Committee must fulfill its mandate in keeping vigilance over the duties and responsibilities given to the administrator.

Finally, this component presents the qualifications required of the facility administrator. The usual prerequisites are outlined: advanced education in health care administration; previous experience in this area; personal qualities and skills and a good working knowledge of the health care system in

⁶⁵ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Position Description," see Appendix I, pp. 328-329.

the Province. Furthermore, under personal qualities and skills, attention is given to a “commitment to the values, philosophy and mission of a Catholic religious hospital facility.”⁶⁶ This could be seen as a further attempt to ensure that the Catholic presence in health care in New Brunswick remains intact.

E. Terms of Reference for Advisory Committees

The fifth component found in the Agreement centers on the important matter of the Advisory Committees. Four terms of reference are given in the Agreement, namely, the mandate of the Advisory Committees, appointment, role and funding. Concerning the mandate, appointment and funding, things appear to be straightforward. However, the role of the Advisory Committees is crucial in the preservation of the mission, philosophy, values and ethics of the Catholic hospital facilities in New Brunswick. Fifteen duties and responsibilities are contained in this section of the Agreement. They are as follows:

- 1- Ensure the preservation and character of the Catholic religious of the Hospital as expressed in the mission statement and the *Catholic Health Care Ethics Guide*.
- 2- Develop the mission statement of the Catholic facility as it relates to the Catholic religious character of the Hospital.
- 3- Develop amendments or revisions of the mission statement from time to time as may be necessary or desirable.

⁶⁶ PROVINCE OF NEW BRUNSWICK, *Agreement*, “Position Description,” see Appendix I, p. 329.

- 4- Verify that the administrator, employees, medical practitioners and others, including Region employees, providing hospital-care services in the Hospital have agreed in writing to abide by the mission statement in effect from time to time.
- 5- Determine the Hospital mission programs and services essential to implement the mission statement and preserve the Catholic religious character of the Hospital. This includes determining program content and delivery agent (s) and covering the direct program cost, as well as direct pastoral-care costs. (The Region Hospital Corporations will cooperate in arranging programs and staff availability to attend these courses/programs, as needed, and will cover staff replacement costs. The Corporation will also cover pastoral-care coordination costs).
- 6- Monitor the operation of the Hospital to ensure that the programs and services determined by the Committee are satisfactorily implemented.
- 7- Formulate and recommend to the Region Hospital Corporation Board any corrective measures necessary to satisfactorily implement those programs and services.
- 8- Appoint 50% of the members of the interview panel which must be constituted to recommend the appointment of an individual to fill a vacancy in the position of the facility administrator.
- 9- Monitor the role and responsibility of the facility administrator as delegated and assigned to the Region C.E.O. to ensure that it is consistent with the job description and the relevant provisions of the Act, Regulations, By-laws and Agreement.
- 10- Monitor the performance of the facility administrator in fulfilling his/her job responsibility to operate the Hospital as a religious hospital and in accordance with the relevant provisions of the Act, Regulations, By-laws and Agreement.
- 11- Monitor committees, interview staff, and review records of the Hospital as may be relevant and necessary to carry out the Committee's role and responsibilities.
- 12- Formulate and recommend to the Region Hospital Corporation Board the steps necessary to ensure compliance with the provisions of the Act, Regulations, By-laws and Agreements that relate to the religious character of the Hospital.

13- Maintain appropriate communication and relationships between the Committee's chairperson, and the Region C.E.O. and the facility administrator as may best facilitate fulfilling the role and responsibilities of the Committee.

14- Ensure that the Hospital maintains active institutional membership in the New Brunswick Catholic Health Association and the Catholic Health Association of Canada, and that the Committee and the Hospital maintain active participation in those associations.

15- Report to (Religious Congregation) in the manner requested by the Congregation with respect to fulfilment of the Committee's terms of reference, and implement such remedial measures as may be identified by the Congregation from time to time.⁶⁷

These Advisory Committees in the future will be the lifeline in preserving and safeguarding the Catholicity of the health care facilities in New Brunswick. All parties to this Agreement acknowledge the important role these Committees have in promoting Catholic involvement in health care. These are models of the kind of influence now being spoken about in terms of sponsorship and governance models in the Catholic health care apostolate in New Brunswick and throughout the country. If these Advisory Committees are taken seriously, as they are meant to be, then the Catholic health care facility will continue to play a predominant role in today's complex health world. A new and unique model of Catholic health care is evolving. Now is the chance to embrace it and make it work.

⁶⁷ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Terms of Reference for the Advisory Committees," see Appendix J, p.331-332.

F. The Lease for Catholic Hospital Facilities

The final component dealt with in the Agreement signed between the New Brunswick Catholic Association, the religious owners of hospital facilities and the Province of New Brunswick centers on the lease for each hospital facility. Using the Standard Form of Lease, the first item deals with the parties to the lease, in this case, the religious institute owning the facility, the particular facility in question, Her Majesty the Queen in Right of the Province of New Brunswick and the Region [...] Hospital Corporation. Following that comes the duration of the lease, which is for a period of 15 years, commencing on April 1, 1992 and terminating on March 31, 2007. Under the item for rental of the hospital facility the sum of \$1.00 per annum, payable annually on April 1 of each year, is stated. The last item on the lease form contains the signatories to the lease, which include representatives of the religious institute, the religious hospital corporation, Region [...] Hospital Corporation and Her Majesty the Queen in right of the Province of New Brunswick (i.e., the Minister of Supply and Services).

Four schedules are attached to the lease form. Schedule A contains the description of property, both land and facilities of the religious hospital facility to be leased by the government. Schedule B lists the obligations on the part of the leasee.⁶⁸ The covenants and conditions of the lease entered into by the lessors and the lessees are set forth in Schedule C of the lease agreement. Most of these conditions and covenants have already been dealt with under the Hospital Act and its

⁶⁸ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Lease," see Appendix K, p. 336.

amendments as well as the Letter of Understanding and Agreement reached on April 21, 1993. These covenants and conditions contained in the lease provide further assurances of the preservation of the Catholic character and the preservation of the mission, values, philosophy and ethics of the Catholic hospital facility in the Province of New Brunswick. Also contained in Schedule C is the annual funding to be paid to the NBCHA on behalf of the religious hospital facility. The stipulation of number 14 (2) of the Schedule states that

the annual funding shall be in the amount of \$150,000.00 to be shared in common for the same purpose with the other Catholic hospitals, and paid in April each year to the New Brunswick Catholic Health Association on their behalf. The amount of the annual funding shall be increased each year by the percentage increase in that year of the hospital services program budget.⁶⁹

This amount of \$150,000.00, shared by all Catholic hospital facilities in New Brunswick could be considered somewhat less than satisfactory considering 130 years of providing quality health care services to the citizens of the Province. Nevertheless, it was an important recognition of the significance of the Catholic Health Association of Canada and the New Brunswick Catholic Health Association.

Finally, the lease concludes with Schedule D stating five essential points. (1) The owners of the Catholic hospital facilities in the Province of New Brunswick remain the religious institutes themselves. (2) A joint review of the debts and liabilities, assets and equity of the religious hospitals

⁶⁹ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Lease," see Appendix K, p. 339.

has been undertaken by the principal participants in the lease, namely, the Province of New Brunswick, the New Brunswick Catholic Health Association and the five religious owners. To date this matter of equity has not been satisfactorily resolved. (3) Acknowledgement is finally given that the religious institutes have operated these hospital facilities up to the enactment of the Hospital Act of 1992. In all the documentation gathered, this is the first time that the government has made such an acknowledgement. (4) The statement is made that this lease corresponds to the terms and conditions reached in the Letter of Understanding of April 21, 1993. (5) The Province of New Brunswick agrees to lease the Catholic hospital facility in order that continued hospital services be provided to the citizens where that hospital facility is located.⁷⁰

The Lease component of the Letter of Understanding and Agreement sums up and puts into legal terms the essential articles already discussed and undertaken by the Province, the NBCHA and the four religious owners. By entering into this Agreement, a new dimension in providing Catholic health care has appeared on the horizon.

CONCLUSION

Chapter Three has presented the pertinent secular legislation in the determination of the canonical status of Catholic health care facilities in New Brunswick. Religious institutes have owned

⁷⁰ PROVINCE OF NEW BRUNSWICK, *Agreement*, "Lease," see Appendix K, p. 340.

and administered these facilities for 130 years without any questions ever being raised regarding ownership, governance or status. Good faith and cooperation have always been a significant part of the relationship between religious institutes and the provincial government in providing proper and quality health care to New Brunswickers.

By examining the various studies, surveys and related documentation, as well as the recent provincial government legislation, the conclusion can be drawn that the canonical status of Catholic health care facilities, namely hospitals, in the Province of New Brunswick has definitely been altered. Though the religious institutes continue to own the property of these facilities in terms of land and buildings, they have, practically speaking, lost the administration and control of the hospital facilities. However, through the Letter of Understanding and the Agreement of 1993 between the New Brunswick Catholic Health Association, the four religious owners and the provincial government, some degree of participation is permissible for Catholic health care facilities in the delivery of health-care services in the Province. The Advisory Committee has become the mechanism for the preservation and promotion of the Catholic character and identity of these facilities. The establishment of this Committee, along with other provisions contained in the Agreement, are meant to serve as safeguards. If the Catholic health care apostolate in New Brunswick is to survive and continue into the next millenium, then these provisions need to be taken seriously. Their full potential needs to be explored and utilized. A challenge has been issued to Catholic health care in New Brunswick. Two options remain: either the government's legislation is viewed as a defeat or it is seen as the dawning of new possibilities, new horizons, whereby influencing what happens in health care and its delivery takes place in a manner consistent with the mission, philosophy, values and ethics that has sustained the Catholic health care apostolate for such a long period in the Province.

CHAPTER FOUR

TRANSFORMATION AND NEW HORIZONS IN THE CATHOLIC HEALTH CARE APOSTOLATE

Today, due to many external and internal factors — decline in religious vocations, the aging of individual religious, government intervention and administration of health care facilities, especially hospitals — new forms of this essential apostolate in the Catholic Church appear on the horizon. The Catholic health care apostolate is being transformed in such a way that its very existence is questioned and, if it is to survive the complexities of the age, then new models of sponsorship¹ and governance

¹ THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES (= CHA), *Inventorying Church Property and Other Administrative Matters*. St. Louis, MO, The Catholic Health Association of the United States, 1994, gives on pp. 12-14 a definition of sponsorship. "Sponsorship is not a technical term either in canon law or civil law, but an umbrella word used to describe the relationship between a religious institute and its apostolic works, both incorporated and unincorporated. Sponsorship commonly means the governance of civilly incorporated institutions or apostolates by public juridic persons usually through the reservation of certain corporate powers for religious leaders. Through such control, these leaders are enabled to fulfill the responsibilities of canonical stewardship. Typically, reserved powers include the right to:

- 1- establish the philosophy according to which the corporation operates;
- 2- amend the articles of incorporation and bylaws;
- 3- appoint or approve the appointment of the Chief Executive Officer;
- 4- appoint or approve the appointment of the Board of Trustees;
- 5- lease, sell or encumber corporate real estate in excess of a specific amount; and,
- 6- merge or dissolve the corporation.

These powers are intended to ensure an appropriate measure of control over ministries identified as Catholic. They enable sponsors to see that their works carry out their mission in the name of the Church and do not act contrary to Catholic faith, morals or canonical discipline. Recently wider definitions of sponsorship have emerged. Besides referring to the type of control described above, the term can also mean the ability to influence the mission and values of a corporation through minority positions on a board of directors or other

must evolve. As many religious institutes no longer have the personnel and resources to cope with health care as before, what possibilities exist for the future?

Chapter Four of this thesis will examine the transformation of the Catholic health care apostolate and its new horizons both in Canada and, more particularly, in the Province of New Brunswick. Part One will present an overview of the evolving models in Catholic health care throughout the country at the present time. Six models seem to be prevalent at this moment. Part Two will deal with the possible canonical models for the Catholic health care apostolate in terms of associations of the Christian faithful, the private juridical person and the public juridical person. In Part Three of this chapter, the various roles involved in preserving the Catholic health care apostolate will be examined; these center on the diocesan bishop, the religious institute and its members, and the laity. All three are seen as partners and collaborators in the health care apostolate and all three play a vital role in maintaining and promoting the mission, values, philosophy and ethics associated with Catholic health care. Finally, Part Four will examine some trends for the future of the Catholic health care apostolate in New Brunswick. From a direct involvement in the health care delivery system, what lies ahead for this apostolate in the Province as it faces many challenging issues at the end of the twentieth century, and moves from institutional apostolates to programs for wellness and health?

forms of advocacy within an institution. Sponsorship can also mean the willingness to allow others to use the good name and reputation of an established health care unit.”

I. EVOLVING MODELS IN CATHOLIC HEALTH CARE

Radical changes have occurred and are still occurring in health care, in religious institutes, and in the Church across the country. These changes have led Canadian leaders in Catholic health care to search for new structures of sponsorship and governance² in order to meet the challenging needs, circumstances and opportunities facing the health care apostolate. Religious sponsors have had to reconsider their roles and seek new models of governance and sponsorship so that the Catholicity of their institutions will be made secure and promoted in the future, taking into account existing provincial legislation. This section will present an overview of the sponsorship and governance models already in place or in the process of being adopted throughout Canada.

A. Unicameral Governance Model

The Catholic Health Association of the United States describes the unicameral model of health care as follows:

Powers previously reserved to a separate member institution are placed within the

² Schedule "A" to a Memorandum of Understanding Between Manitoba Health and Certain Faith-Related Institutions: *A Statement of Governance by the Inter-Faith Association*. April, 1994, on p. 6, defines governance as "the ability exercised by a group of dedicated people to determine the philosophy, purpose, mission and operation of its organizations. In other words, governance decides why an organization exists, who comprises it, what it tries to do and how it does it."

corporate board of a health system. The Board is organized into Class I and Class II Directors, with reserved powers accruing to only one class.³

The board or some of its members also exercise many of the canonical rights and obligations. With this model of health care, those sponsoring health care institutions have a direct say in the policies and decisions affecting their facilities. Furthermore, the decisions taken in such a system are efficient, controlled, and unified; Catholic presence and identity are preserved. This particular model of health care, though prominent in the United States, exists in this country in two health care systems — the Hamilton Health System and the RHSJ Health System.

Established in 1991, the St. Joseph's Health Care System⁴ comprises health care facilities owned by the Sisters of Saint Joseph of Hamilton, ON. Each facility in the system has its own Board of Trustees with wide-sweeping powers governing that particular facility. A Board of Directors, made up of the General Superior and 5 Council members, the General Treasurer and lay members, governs the whole health care system.

The second unicameral governance structure to be found in Canada is the RHSJ Health System. Founded also in 1991, it comprises those health care facilities, health centres and nursing

³ CHA, *In Their Own words ... An Assessment of Evolving Health Care Arrangements by the Sponsors Who Use Them*. St. Louis, MO, The Catholic Health Association of the United States, 1996, p. 11.

⁴ The Sisters of St. Joseph reserve to themselves any substantive changes to the philosophy or mission of the member institutions. Also, it should be noted that each hospital facility has its own Board of Trustees while the Board of Directors oversees the whole St. Joseph's Health Care System.

homes — each separately incorporated — located in Ontario, New Brunswick, Illinois, Wisconsin and the Dominican Republic. The system approves changes in the philosophy and mission of the health care facilities; authorizes the amendment of the act of incorporation and bylaws; appoints the Board of Directors; appoints or dismisses the CEO; leases, sells or encumbers corporate assets; approves capital and operating budgets; appoints the Auditor; authorizes the merging or dissolution of the Corporation. In addition to these features, both the General and Provincial Administrations of the Religious Hospitallers of St. Joseph reserve to themselves certain acquisitions or disposal of real estate of the Corporation; the mortgaging or pledging as security any assets of the Corporation, the merger or dissolution of the Corporation, and any joint ventures/affiliations that would occur.⁵

Clearly, with this model of health care, the Hamilton Health System and the RHSJ Health System assume general responsibility for the direction of the apostolate entrusted to them, subject to the authority of the competent major superiors. As well, this model allows for the involvement and collaboration of dedicated and experienced lay people in the apostolate of caring for the sick. By pooling together the resources and expertise, this unicameral governance model allows for the continued advancement of the mission, values and philosophy of the health care system, while at the same time allowing for necessary autonomy in the individual facility.

⁵ RELIGIOUS HOSPITALLEERS OF SAINT JOSEPH, *RHSJ Health System: Governance Responsibility*. Kingston, ON, Religious Hospitallers of Saint Joseph, 1991, p. 2.

B. Diocesan Sponsorship Model

Relatively new to health care in recent years, the Diocesan Sponsorship model is found in the Province of Ontario. Applying mostly to facilities belonging originally to the Sisters of St. Joseph, this model is used in the Dioceses of London, ON and Peterborough, ON. Known as the St. Joseph's Health Care Society of London and the Fontbonne Health Care Society of Peterborough, both have been established as public juridic persons of diocesan right and encompass hospitals and nursing home facilities.

St. Joseph's Health Care Society grew out of three facilities situated in London, Chatham and Sarnia, ON, belonging to the Sisters of St. Joseph of London, ON.— St. Joseph's Health Centre, Chatham, ON, St. Joseph's Health Centre, London, ON, and St. Joseph's Health Centre, Sarnia, ON. On the other hand, the Fontbonne Health Care Society, incorporated on September 21, 1985, is made up of St. Joseph's Hospital and Health Centre; the Englewood Senior Residence, and the Marycrest Home, all located in the Diocese of Peterborough. Both Health Care Societies have essentially the same principal features concerning governance such as (1) own, operate and manage health care facilities; (2) develop, approve, amend philosophy or mission; (3) approve, amend, change the constitution or bylaws; (4) appoint and remove directors; (5) appoint and remove the chairperson of the board; (6) lease, sell or encumber assets; (7) approve sale of a major asset and borrow money; (8) merge, dissolve or alter the juridic person; and (9) appoint an auditor. Certain reserved

powers in these specific areas pertain to the Bishop of each diocese respectively.⁶

C. Sponsorship Ecclesiastical Provinces

Under a third model, three examples exist of sponsorship by ecclesiastical provinces. The Alberta Catholic Health Corporation; the Catholic Health Council of Saskatchewan, and the Catholic Health Sponsors of Ontario.

First established as a civil foundation known as the "Alberta Catholic Hospital Foundation" in 1976, the Archbishop of Edmonton established it as a public juridic person of diocesan right in 1993. This Foundation became responsible for two Catholic health care facilities: St. Michael's General Hospital, Lethbridge and Mineral Springs Hospital in Banff, AB. Reorganized in 1997 under a new name, the "Alberta Catholic Health Corporation" would continue the tradition, presence and identity of the Catholic health care apostolate in that province. By involving not only members of

⁶ DIOCESE OF LONDON, *Statutes of St. Joseph's Health Care Society*. London, ON. September 25, 1993. The reserved powers are as follows:

1. The directors are to be confirmed in office for canonical purposes by the Bishop of the Diocese. A director may be removed from office according to the procedures outlined in the official corporate documents subject to confirmation by the Bishop of the Diocese.

2. The Health Care Society shall present an annual report of its activities to the Bishop of the Diocese for approval.

3. The Society may be dissolved or suppressed as a public juridic person in the Church by the Bishop of the Diocese, for cause, after having heard the interested parties.

4. In the case of the dissolution or suppression of the Health Care Society as a public juridic person in the Church, any temporal goods belonging to it, after all debts have been discharged and the intentions of donors complied with, shall be distributed, in consultation with the Bishop of the Diocese, to a recognized not-for-profit charity for use in promoting the healing ministry.

5. Statutes of the Health Care Society may not be changed without the expressed authorization of the Bishop of the Diocese.

religious institutes but also members of the laity who desire to offer their time, talent and energy to this essential apostolate in the Church, the path to the future would be solidly established.

Establishment as a public juridic person allows the Alberta Catholic Health Corporation to act more directly in the name of the Church through the juridic person.⁷ The Corporation is subject to the canonical regulations concerning its administration; its temporal goods are considered ecclesiastical goods. This is a relatively new concept for health care in this country and only time and experience will measure its success as a future model in the Canadian Catholic health care apostolate.

A second example of sponsorship by bishops of ecclesiastical provinces can be found in the Province of Saskatchewan. It groups Radville Community Hospital, Radville, SK; St. Joseph's Hospital, Ile-à-la-Crosse, SK; St. Martin's Hospital, La Loche, SK; St. Peter's Hospital, Melville, SK;

⁷ ALBERTA CATHOLIC HOSPITALS FOUNDATION, *Statutes of the Alberta Catholic Hospitals Foundation*. Edmonton, AB, February 25, 1993. The following powers are reserved to the Archbishop of Edmonton:

1. An annual report of the operations of the Corporation shall be presented for information purposes to the Archbishop of Edmonton at a mutually agreed-upon time (c. 1287).

2. Any change in the Corporation's canonical status is reserved to the Archbishop of Edmonton (or any successor Bishop).

3. Subject to civil law commitments, in the event that the Corporation would cease to exist as an independent entity, the temporal goods of the Corporation shall be disposed of in accordance with the prescriptions of both canon 123 and the applicable civil legal documents governing the Alberta Catholic Health Corporation. In case of conflict between the two sets of norms, the matter shall be referred to the Archbishop of Edmonton, or to a person of his choice, for resolution and, subject to the Corporation's commitments at civil law, the temporal goods shall be dealt with in accordance with such resolution.

4. Any change in the canonical statutes requires the consent of the Archbishop of Edmonton.

and, St. Joseph's Hospital, Estevan, SK. Known as the "Catholic Health Council of Saskatchewan," this association is

an ownership group that, on behalf of the Catholic community of Saskatchewan, maintains and fosters Catholic mission, values and ethics in health care by providing responsible stewardship through empowerment of local boards in those facilities within its mandate.⁸

Each health care facility in the Province continues to be separately incorporated. However, the Council is in a strong position to safeguard the presence and identity of the Catholic health care apostolate in Saskatchewan. The principal features allowing the Catholic Health Council to carry out its mandate are: approving any change in the philosophy of the Corporation; amending the charter and bylaws of the Corporation; appointing and approving the board of directors; entering into real estate transactions above a specified amount; merging or dissolving the Corporation; and, appointing and approving the Chief Executive Officer of the Corporation.

Once again, this model is in the stage of infancy and will be watched carefully in health care circles for further possibilities of adopting it elsewhere in parts of the country looking for new avenues of sponsorship and governance. Discussions are underway at the present time concerning the possibility of obtaining juridical personality for the Council.

⁸ E. MACNEIL, *Catholic Health Council of Saskatchewan: Governance and Operational Review*. Final Report, July 30, 1997, p. 6.

A third group could enter under this heading; it too comprises more than one ecclesiastical province. Established as a public juridic person of pontifical right on November 24, 1997, the "Catholic Health Sponsors of Ontario" comprises health care facilities belonging to the Sisters of St. Joseph of Toronto, the Sisters of St. Joseph of Sault Ste. Marie and the Grey Sisters of the Immaculate Conception of Pembroke, ON.⁹ Similar in nature to the Alberta Catholic Health Corporation, the Catholic Health Sponsors of Ontario, by becoming a public juridic person of pontifical right, acts officially in the name of the Church and provides for the continuation of the long legacy of health care started by the various religious institutes in that Province. In addition to the regular features, the Catholic Health Sponsors of Ontario relate to the Holy See in the following way:

1. The Holy See shall receive an annual report which gives evidence that the integrity of faith and morals is preserved and that the use of the temporal goods and the apostolic activity of the Catholic Health Sponsors of Ontario are in accord with its purposes.
2. The Holy See may request a meeting with the Catholic Health Sponsors of Ontario to discuss its apostolate.

⁹ The following health care facilities make up at the present time the Catholic Health Sponsors of Ontario: Facilities belonging to the Sisters of St. Joseph of Toronto, ON include St. Joseph's Health Centre, Providence Centre, and St. Michael's Hospital, all located at Toronto, ON. The facilities owned by the Sisters of St. Joseph of Sault Ste. Marie, ON, include The Sudbury General Hospital, Sudbury, ON, St. Joseph's General Hospital, Elliot Lake, ON, St. Joseph's Health Centre, Blind River, ON, and St. Joseph's Care Group, Thunder Bay, ON. Facilities belonging to the Grey Sisters of the Immaculate Conception of Pembroke include Marianhill Inc., Pembroke, ON, Pembroke General Hospital Inc., Pembroke, ON, Sault Ste. Marie General Hospital Inc., Sault Ste. Marie, ON, St. Patrick's Home of Ottawa Inc., Ottawa, ON, and Penetanguishene General Hospital Inc., Penetanguishene, ON.

3. The Catholic Health Sponsors of Ontario recognizes that the Holy See accepts no financial responsibility regarding the Catholic Health Sponsors of Ontario and its affairs.
4. The Catholic Health Sponsors of Ontario may be suppressed:
 - a) by the Holy See for failure to act in accord with its statutes; or
 - b) by the Holy See upon the request of three-quarters of the members of the Catholic Health Sponsors of Ontario.
5. Amendment of the statutes is reserved to the Holy See upon the request of two-thirds of the members of the Catholic Health Sponsors of Ontario.¹⁰

¹⁰ CATHOLIC HEALTH SPONSORS OF ONTARIO, *Canonical Statutes*. Toronto, ON, 1997, pp. 4-5. See also CATHOLIC HEALTH SPONSORS OF ONTARIO, *Provincial Juridic Person for Sponsorship*. CHAO Board of Directors Agenda, June 2, 1997. On pp. 2-3 the principal features to be found with this model are outlined as: (a) the ownership, operation and management of any type of public hospital, including a hospital for the chronically and terminally ill, a rehabilitation hospital, a community health centre and out-patient treatment and support facility; ancillary facilities or services for any such hospitals; any health related type of service; (b) provide a vehicle for the continuation of the Catholic health ministry; (c) maximize the potential for collaboration and sharing among institutions; (d) preserve and enhance the local presence of the Catholic health ministry in communities where institutions exist; (e) carry on such other business or exercise such other powers as the Corporation's members may stipulate; (f) the Corporation shall be carried on without purpose of gain for its members and any profits or other gains to the Corporation shall be used in promoting its objectives; and (g) for the above objects, and as incidental and ancillary thereto, to exercise any of the powers prescribed by the Canada Corporations Act, or by any statutes or laws from time to time applicable (except if the Corporation is registered as a Canadian charitable organization with Revenue Canada Taxation, such powers will not be exercised which are contrary to the statutes or common law relating to Canadian charitable organizations), and in particular, but without limitation: (i) to solicit and receive donations, bequests, legacies and grants, and to enter into agreements, contracts and undertakings incidental thereto; (ii) to acquire, by purchase, contract, donation, legacy, gift, grant, bequest or otherwise, any personal property and to enter into and carry out any agreements, contracts or undertakings incidental thereto, and to sell, dispose of and convey the same, or any part thereof, as may be considered advisable; (iii) to acquire by purchase, lease, devise, gift, or otherwise, real property and to hold such real property or interest therein necessary for the actual use and occupation of the Corporation or for carrying on its undertakings, and, when no longer so necessary, to sell, dispose of and convey the same or any part thereof; (iv) to employ and pay such assistants, clerks, agents, representatives and employees, and to procure, equip and maintain such offices and other facilities and to incur such reasonable expenses as may be necessary, provided that the Corporation shall not pay any remuneration to a director in any capacity whatsoever; (v) to cooperate, liaise, and contract with other organizations, institutions or agencies which carry on similar objects to that of the Corporation; (vi) to demand and compel payment of all sums of money and claims to any real or personal property in which the Corporation may have an interest and to compromise any such claims, and generally to sue and be sued in its corporate name; (vii) to draw, make, accept, endorse, execute and issue cheques and

D. Catholic Health Care Group Model

A fourth model comprises two groups — the “Vancouver Catholic Health Care Group” and the “Caritas Health Group” in Alberta. The first group, the Vancouver Catholic Health Care Group was established in March of 1997 and is made up of the Chara Health Care Society,¹¹ St. Paul’s Hospital, owned by the Sisters of Charity of Providence in British Columbia, and Holy Family Hospital, owned by the Sisters of Providence of St. Vincent de Paul, Kingston, ON. At the present time, the three partners involved in the Health Care Group retain their separate legal entities, while agreeing on a structure whereby they can continue to operate and manage their individual health care facilities. The process of becoming a public juridic person has begun for the Vancouver Health Care Group and in the not too distant future the decree of the competent ecclesiastical authority should be promulgated.

In a memorandum concerning the Vancouver Catholic Health Group the following description is given:

other negotiable or transferable instruments; (viii) to exercise all voting rights and to authorize and direct the execution and delivery of proxies in connection with any share in or obligations of any company or corporation held by the Corporation; (ix) to pay all costs and expenses of or incidental to the Corporation; and (x) to do all such things that are ancillary and incidental to the attainment of the objects of the Corporation.

¹¹ Chara Health Care Society is a partnership formed in Vancouver in 1994 made up of Mount St. Joseph Hospital, owned by the Missionary Sisters of the Immaculate Conception, Montreal; St. Vincent’s Hospital, (on four sites), owned by the Sisters of Charity of the Immaculate Conception, Saint John, NB; and Youville Residence, owned by the Grey Sisters of the Immaculate Conception, Pembroke, ON. Chara Health Care Society received public juridical personality of diocesan right on October 7, 1994.

A cluster organization within the Vancouver/Richmond Health Region which accommodates the regionalization policies of the Ministry of Health and the Vancouver/Richmond Health Board but at the same time preserves the 'spirit' of the Master Agreement, strengthens the mission and values of Catholic health care, maintains the identity of the five surrounding communities with their respective facilities, and protects ownership interests.¹²

The principal features of the Vancouver Catholic Health Care Group are: (1) retention of three separate legal entities; (2) delegation of authority; (3) retention of non-delegated responsibilities; (4) protection of equity interests; (5) a Joint Governance Board; (6) voting rights at meetings of the Joint Governance Board; (7) officers of the Joint Governance Board; (8) appoint president/CEO; (9) common management team; (10) committees; (11) termination of or withdrawal from the cluster agreement; and (12) agreement with respect to financial issues.

The second participant in this model of Catholic health care is the Caritas Health Group of Alberta. It works in close association with the Alberta Catholic Health Corporation. Its present members consist of the Edmonton General Hospital; the Grey Nuns Hospital of Edmonton and the Misericordia Hospital, Edmonton. Provisions are made for additional membership in this Health Group by other interested Catholic health care facilities. Coming together as a unified body, the purpose of the Caritas Health Group is to preserve and maintain the mission and philosophy of

¹² BULL, HOUSSEY & TUPPER, *Memorandum: Vancouver Health Care Group*. Vancouver, BC, March 13, 1997, pp. 2-9.

the Catholic health care apostolate in the Province of Alberta. To achieve its desired purpose the following principal features are:

- 1- Developing and approving the mission and values according to which both the Corporation and the Hospitals operate.
- 2- Approving the member institution's bylaws and amending the same.
- 3- Approving the Board of Directors' bylaws.
- 4- Having the power to appoint and remove the Directors of the Corporation.
- 5- Having the power to lease, sell, borrow or encumber assets of the Grey Nuns Corporation and the Misericordia Hospital Corporation, including real estate, provided that the members will obtain the prior approval of the Holy See of the amount of those assets which are leased, sold, borrowed or encumbered and are in excess of the amount established by the Holy See for the region as being in the region's authority.
- 6- Having the power to create corporations or merge, dissolve or alter the Corporation.
- 7- Approving the bylaws of new corporations.
- 8- Notwithstanding anything contrary contained in section 3.1 c or any other Article herein, to amend, repeal or enact Director's bylaws at any time when in their opinion such enactments or amendments are reasonably necessary to ensure that the hospitals are being operated lawfully and in a manner consistent with:
 - (i) the medical moral code approved from time to time by the Canadian Conference of Catholic Bishops or any successor organization;
 - (ii) Article II of these bylaws relating to the mission and values statement of the Corporation; and
 - (iii) the Canon Law of the Roman Catholic Church.¹³

¹³ CARITAS HEALTH GROUP, *By-Laws for the Members of the Caritas Health Group*, Edmonton, AB, 1993, pp. 8-9.

E. **Agreements Relinquishing Ownership and/or Governance**

Three provincial agreements in Eastern Canada provide for a fifth form of governance — Newfoundland, Nova Scotia and New Brunswick. This particular section will deal only with the Provinces of Newfoundland and Nova Scotia, namely, St. Clare's Mercy Hospital, St. John's, NF, and St. Martha's Regional Hospital, Antigonish, NS. These institutions are still considered to be Catholic hospitals.

The Sisters of Mercy and the Government of Newfoundland signed an agreement in December 1994 thereby transferring the ownership of St. Clare's Mercy Hospital. Likewise, the authority once held by the Board of St. Clare's was transferred to a regional board. Under the terms of the agreement, the lands and assets associated with this health care facility became the property of the Government of Newfoundland. However, the Sisters of Mercy retain a certain influence in terms of the mission of the hospital and provisions were made whereby the hospital would continue to follow the *Health Care Ethics Guide*. At the same time an Advisory Council would be established with two persons nominated by the Sisters for appointment to the St. John's Regional Hospital Board. As well, the approval of the Sisters of Mercy was to be received in the appointment of the hospital administrator. Finally, the Government of Newfoundland agreed to purchase the St. John's facility from the Sisters of Mercy for the sum of \$20,000,000.00 spread over a period of twenty years.

Under the terms of this agreement reached between the Sisters and the Newfoundland government, an Advisory Council at St. Clare's Hospital was entrusted with authority and responsibility to see that the Catholicity of the hospital be retained by ensuring that the mission, values and philosophy found in the spirit and tradition of St. Clare's Mercy Hospital are promoted. The principal features associated with the St. Clare's Mercy Hospital Advisory Council include the following:

- 1- The Advisory Council reports to the Board of Trustees of the Health Care Corporation of St. John's.
- 2- The Council gives effect to the provisions of the Agreement between the Congregation of the Sisters of Mercy, St. Clare's Mercy Hospital and the Minister of Health.
- 3- The Council determines mission programs and mission services essential to maintaining the mission, values and philosophy of St. Clare's.
- 4- The Council accepts responsibility for developing and revising the mission paragraph in the Board bylaws as it relates to the mission, values, philosophy, and ethics of St. Clare's.
- 5- The Council monitors the performance of the Administrator of St. Clare's in the operation of St. Clare's only in matters which relate to the mission, values, philosophy and ethics and ensures the orientation and continuing education of the administrator in these areas.
- 6- The Council reports regularly to and provides direction for the Board on matters related to mission, values, philosophy and ethics at St. Clare's; receives regular summaries of operations from the Board; and, also has access to such other information as is necessary to carry out its responsibilities.
- 7- The Council ensures that all medical staff, employees and volunteers at St. Clare's agree to abide by the mission, values, philosophy and ethics.

- 8- The Council oversees continuation of the Mission Effectiveness Program, the Pastoral Care Department and the Ethics Committee at St. Clare's.
- 9- The Council maintains names, symbols and mottos which reflect the mission, values and philosophy of St. Clare's.
- 10- The Council initiates special activities and ceremonies at St. Clare's related to continuation of the mission.
- 11- The Council advises the Regional Board on changes to the bylaws which relate to St. Clare's to ensure these bylaws respect the mission, values and philosophy and the operation of St. Clare's within the ethics guidelines.
- 12- The Council advises the Regional Board when considering changes in programs and services at St. Clare's which may have implications for the mission, values and philosophy.
- 13- The Council advises the Congregation of the Sisters of Mercy on nomination of members to represent the Congregation on the Regional Board.
- 14- The Council maintains linkages with the St. Clare's Mercy Hospital Foundation and the Hospital Auxiliary as long as these separate organizations exist.
- 15- The Council is permitted to hold its meetings in St. Clare's and is provided with general secretarial support for these meetings.¹⁴

This agreement reached between the Sisters of Mercy and the Government of Newfoundland is a clear example of the kind of influence that can be had in the health care delivery system today even when ownership is transferred. Indeed, the arrangement between the religious institute and the government is the product of a well thought out strategy to permit the Catholicity of the health care facility to remain viable and active in years to come.

¹⁴ PROVINCE OF NEWFOUNDLAND, *Agreement Between the Government of Newfoundland, St. Clare's Mercy Hospital and the Congregation of the Sisters of Mercy of Newfoundland*, St. John's, NF, Province of Newfoundland, 1994, pp. 3-5.

With the construction and opening of the new St. Martha's Regional Hospital in Antigonish, Nova Scotia, an agreement similar to the one struck in Newfoundland between religious and civil authorities was reached in 1996. The parties to this agreement were the Sisters of St. Martha and the Government of Nova Scotia. The Agreement transferred the operation and management of St. Martha's Regional Hospital to the Province of Nova Scotia while at the same time confirming St. Martha's to be a vital component of the new health care system emerging in that Province. The Agreement of 1996 recognized the long tradition and role played in the health care delivery system by the Sisters of St. Martha. Likewise, their contribution to the well being of the citizens of that Province, past and present, was acknowledged and their future commitment to health care encouraged. Under the terms of the Agreement, the Sisters of St. Martha and the Government of Nova Scotia agreed that the fundamental principles of respect for the dignity of each patient, family members, and hospital personnel continue in the new facility. Furthermore, the principles and practices contained in the *Health Care Ethics Guide* would continue to be followed as well as any other ethical principles or practices adopted by the government upon the advice of the Advisory Council.

Like the Newfoundland Agreement, in order to safeguard and promote Catholicity at St. Martha's Regional Hospital, the government of Nova Scotia and the Sisters of St. Martha mutually agreed to the establishment of an Advisory Council. Among the principal features contained in the

Agreement allowing for a continued Catholic presence in the health care system in Nova Scotia, the following are noteworthy:

- 1- The Sisters of St. Martha continue to witness to the care for the physical, emotional and spiritual health of people served by St. Martha's.
- 2- St. Martha's continues to promote a vision of life, based on human, Christian, ethical and spiritual values, values expressed in the mission and philosophy of St. Martha's and in the principles and practices of the *Health Care Ethics Guide*.
- 3- The parties agree to continue to be guided by a spirit of collaboration for the promotion of quality health care.
- 4- The parties acknowledge the significant relationship and collaboration between the Sisters, St. Martha's Hospital, and the local community served by the hospital and agree to continue to respect and promote this relationship.
- 5- A Site Manager Selection Panel consisting of six members is to be created. Three members shall represent the Sisters of St. Martha and three members shall represent the Government of Nova Scotia. The Panel shall screen and interview candidates for the position of Site Manager of St. Martha's and present a recommended candidate for the approval of the Government.
- 6- The Site Manager for St. Martha's shall abide by the mission, values, philosophy and the *Health Care Ethics Guide* as contained in the Mission Statement, Philosophy Statement and the Health Care Ethics Statement of Principles and with those aspects of job description related to the mission, values, philosophy and the *Health Care Ethics Guide* which are to be determined by mutual agreement between the Sisters and the Government.
- 7- All outward manifestations of a Catholic Hospital shall remain.
- 8- St. Martha's shall be administered in accordance with the mission, values, philosophy and the *Health Care Ethics Guide*.
- 9- There shall be an Advisory Council appointed by the Government upon nomination by the Sisters of St. Martha, which shall advise the Government and Sisters on ethical principles.

10- The Government further acknowledges the prerogative of the Advisory Council to recommend to the Government measures necessary to ensure compliance by personnel, volunteers and medical practitioners with the mission, values, philosophy and the *Health Care Ethics Guide*.

11- The Advisory Council and the Sisters may provide initiatives, subject to the Site Manager's approval, which support the mission, values, philosophy and the *Health Care Ethics Guide*.

12- The Government shall recognize the role of the Mission Coordinator and the continuation of the service of the Pastoral Care Ministry as essential components of this Agreement in support of the mission, values, philosophy and the *Health Care Ethics Guide*.

13- The Sisters of St. Martha through the Site Manager shall approve the appointment of personnel to these services.

14- The Mission Coordinator shall as a term of employment accept the mission, values, philosophy and the *Health Care Ethics Guide*.¹⁵

Once again, this Agreement responds to the situation of health care reform and guarantees some degree of participation by the Church in the health care system in Nova Scotia. From direct ownership and administration to a position of influence, the Catholic health care apostolate is nevertheless preserved and enhanced in that Province.

¹⁵ PROVINCE OF NOVA SCOTIA, *Agreement Between the Sisters of St. Martha, Eastern Regional Health Board, St. Martha's Regional Hospital, and the Province of Nova Scotia*. Antigonish, NS, Province of Nova Scotia, 1996, pp. 4-7.

F. Provincial Governance Agreements

In the Provinces of Manitoba, Saskatchewan, Alberta and British Columbia, there exist provincial governance agreements between faith-sponsored health care facilities and the respective governments. To date, these agreements have no equivalent canonical status as such. The agreements can and do overlap with the Catholic Health Care Groups in British Columbia, Alberta and Saskatchewan.

In the Provinces of Saskatchewan, Alberta and British Columbia the agreements call for owners of faith-sponsored health care facilities to manage or continue to manage the fiscal, human and physical resources under their control so as to meet the terms entered into with the regional hospitals and the national and provincial standards set for health care. As well, owners of the faith-sponsored facilities are to approve and implement any staff plan and provide for assisting the placement of staff affected by regionalization of the health care delivery systems in those Provinces. In British Columbia only, the Agreement provides for consultation on the appointment of the Chief Executive Officer. A common feature among all four provinces allows each facility or ownership group to appoint its Board of Directors; employ an Executive Director; choose, select, employ and dismiss all staff and grant or revoke medical staff privileges.¹⁶

¹⁶ CHAC, *Governance Agreements Negotiated by Catholic Health Care in Western Canada*. The Catholic Health Association of Canada, Ottawa, 1995, p. 3.

Having presented an overview of the evolving models of sponsorship and governance in the Catholic health care apostolate today, attention now focuses on the possible canonical models.

II. CANONICAL MODELS FOR CATHOLIC HEALTH CARE

With the radical changes occurring in health care throughout the country at all levels, new forms of sponsorship and governance are evolving in order to ensure a Catholic presence in the delivery of health care services. With the promulgation of the 1983 Code of Canon Law, great emphasis is placed on the active participation of all persons within the Church — clergy, laity and religious — in the varied works of the apostolate, including the health care apostolate. Among the possibilities provided in canon law, three will be dealt with in this section: the private association of the Christian faithful, the private juridic person and the public juridic person.

A. Associations of the Christian Faithful

Since the Second Vatican Council and the promulgation of the 1983 Code of Canon Law, the role of the laity in the life of the Church has gained place of prominence.¹⁷ The laity have both the

¹⁷ *CIC 1983*, c. 225, §1: “Laici, quippe qui uti omnes christifideles ad apostolatum a Deo per baptismum et confirmationem deputentur, generali obligatione tenentur et iure gaudent, sive singuli sive in consociationibus coniuncti, allaborandi ut divinum salutis nuntium ab universis hominibus ubique terrarum cognoscatur et accipiatur: quae obligatio eo vel magis urget iis in adiunctis, in quibus nonnisi per ipos Evangelium audire et Christum cognoscere homines possunt.” See also SECOND VATICAN COUNCIL (= VATICAN II), Dogmatic Constitution on the Church, *Lumen gentium* (=LG), n. 33, 21 November 1964, in *Acta Apostolicae Sedis* (= AAS), 57 (1965), p. 39. (English translation in A. FLANNERY, (ed.), *Vatican*

right and the obligation to share in the mission of the Church. This most certainly would include the health care apostolate. With the onset of dramatic changes in health care, especially in the United States in the 1970s and 1980s, one of the ways envisioned by the Catholic Health Association of the United States in terms of alternative sponsorship by the laity was the canonical provision of the association of the Christian faithful.

Associations within the Church are dealt with in Book II of the 1983 Code and treated in canons 298-329. Basically, two types exist — public and private associations. More specifically, canons 321-326 deal with the private association, which can be described as a “group of the Christian faithful who have united at their own initiative, according to specific statutes, for an apostolic work or ministerial purpose.”¹⁸ Though under the watchfulness of the proper ecclesiastical authority, these private associations are not established by such authority. However, the statutes of such an association would be reviewed, unless they require recognition, by the ecclesiastical authority competent to do so.

Council II: The Conciliar and Post Conciliar Documents (= FLANNERY), new rev. ed., vol. 1, Northport/New York, Costello Publishing Co., 1984, pp. 390-391; VATICAN II, Decree on the Apostolate of Lay People, *Apostolicam actuositatem* (= AA), n. 2, 3, 17, 18 November 1965, in *AAS*, 58 (1966), pp. 838-840, 852. (English translation in FLANNERY, vol. 1, pp. 767-768, 768-769, 784); VATICAN II, Decree on the Church Missionary Activity, *Ad gentes* (= AG), n. 21, 36, 7 December 1965, in *AAS*, 58 (1966), pp. 972-973, 983-984. (English translation in FLANNERY, vol. 1, pp. 838-839, 850).

¹⁸ M. MODDE, “Private Association: Opportunity for Laity,” in *Health Progress*, 67 (1986) 9, p. 49. See also R. PAGÉ, “Associations of the Faithful in the Church,” in *The Jurist*, 47 (1987), pp. 191-196.

Canon 298 treats of the three apostolic purposes undertaken by associations in the Church, such as the exercise of apostolic works, the exercise of works of piety and the infusion of the temporal order with the Christian spirit.¹⁹ The statutes of each association (public or private) could include more specific purposes in keeping with the nature of the association.

Unlike those of the public association in the Church, the temporal goods of the private association of the faithful are owned and administered by the association. They are not classified as ecclesiastical goods, although the proper ecclesiastical authority does possess the right to keep watch lest these goods be used for purposes not intended by the association and its statutes. Likewise, the private association is obliged to follow the norms of law concerning any donated goods.

The Catholic Health Association of the United States describes both the public and private association of the Christian faithful in the following terms:

¹⁹ *CIC 1983*, c. 298§1: "In Ecclesia habentur consociationes distinctae ab institutis vitae consecratae et societatibus vitae apostolicae, in quibus christifideles, sive clerici sive laici, sive clerici et laici simul, communi opera contendunt ad perfectiorem vitam fovendam, aut ad cultum publicum vel doctrinam christianam promovendam, aut ad alia apostolatus opera, scilicet ad evangelizationis incepta, ad pietatis vel caritatis opera exercenda, temporalem christiano spiritu animandum." See also VATICAN II, Decree on the Pastoral Office of Bishops in the Church, *Christus Dominus* (= CD), n. 17, 28 October 1965, in *AAS*, 58 (1966), pp. 681-682. (English translation in FLANNERY, vol. 1, pp. 573-574); VATICAN II, Decree on the Training of Priests, *Optatam totius* (= OT), n. 2, 28 October 1965, in *AAS*, 58 (1966), p. 714. (English translation in FLANNERY, vol. 1, pp. 708-710); VATICAN II, Declaration on Christian Education, *Gravissimum educationis* (= GE), n. 6, 8, 28 October 1965, in *AAS*, 58 (1966), pp. 733-734, 734-736. (English translation in FLANNERY, vol. 1, pp. 731-732, 732-734); VATICAN II, AA, n. 5-8, 11, 18, 19, in *AAS*, 58 (1966), pp. 842-846, 847-848, 852-854. (English translation in FLANNERY, vol. 1, pp. 772-776, 778-780, 784-786); VATICAN II, Decree on the Ministry and Life of Priests, *Presbyterorum ordinis* (= PO), n. 8, 7 December 1965, in *AAS*, 58 (1966), pp. 1003-1005. (English translation in FLANNERY, vol. 1, pp. 878-880).

Associations are established among the Christian faithful by means of a agreement to strive by common effort to promote a more perfect life, to foster public worship or Christian doctrine, or to exercise other apostolic works, namely to engage in efforts of evangelization, to exercise works of piety or charity, and to animate day-to-day life with the Christian spirit.²⁰

Some advantages for the establishment of an association of the faithful could be to enable a health care facility to remain or become Catholic; to provide opportunities for the laity to become more involved in the health care apostolate; and to allow a certain autonomy within specific guidelines. At the same time, there definitely exist disadvantages to this model. It focuses primarily on persons and not on the work of the health care apostolate. Another area which could possibly be of concern involves personnel not sharing the same beliefs and values upheld by the Catholic facility. Few health care facilities operate under this particular model and in this country none have as yet adopted this model. A definite confusion exists in terms of accountability, and a lack of communication could result between the organization and the sponsoring body. It has been reported as well that some diocesan officials offer little if any supervision of the association involved in health care. Finally, issues surrounding Catholic identity can cause image problems in the larger community.

In terms of responsibilities towards the private association of the faithful, the diocesan bishop does play a rather significant role, although it is not one of direct involvement. It is his responsibility to review the statutes of the private association of the faithful if it seeks official ecclesial recognition (c. 299, §3); to grant permission for

²⁰ CHA, *In Their Own Words*, p. 21.

the association to use the name 'Catholic' (c. 300); to keep vigilance over faith and morals (c. 305, §1); to oversee the coordination of the apostolic works of the private association (c. 323, §2); and to supervise wills and bequests (c. 325, §2). Finally, he has the right to ensure that the private association of the faithful manages its funds according to the provisions of its statutes (c. 325, §1).²¹ As to public associations, his duties are clearly spelled out in relation to the application of cc. 312-320.

In terms of the health care apostolate, the private association of the faithful could be entrusted with the sponsorship of the health care apostolate in the community. The members would be required to adhere to the *Health Care Ethics Guide* and the canon law of the Church, be committed to the mission, values, and principles of Catholic health care, and participate in education programs centred on the Catholic health care apostolate.²²

The Code of Canon Law provides for the cessation of the private association of the faithful in two ways: provisions found in the statutes, and intervention by an ecclesiastical authority if the association violates the Church's faith and morals (cc. 320-326). Canon law also encourages associations to collaborate with other groups active in the apostolate.²³

²¹ MODDE, "Private Association: Opportunity for Laity," p. 48.

²² Ibid., p. 50.

²³ PAGÉ, "Associations of the Faithful in the Church," p. 197.

Although the association of the faithful model was put forward by the Catholic Health Association of the United States some years ago as an alternative sponsorship model, it has not yet been adopted in this country and it seems rather unlikely ever to be used here as one of the evolving models of sponsorship and governance.

B. Private Juridic Person

The notion of juridic person in the Church has already been dealt with sufficiently in Chapter Two of this thesis. Nevertheless, a few further clarifications are in order regarding the entity known as the private juridic person. Along with the association of the Christian faithful, the private juridic person as an alternative model of sponsorship in the health care apostolate was proposed by the Catholic Health Association of the United States in the mid-1980s. A new category in the 1983 Code, the private juridic person does not act on behalf of the Church officially. However, establishment by the decree of the competent ecclesiastical authority gives official recognition and status in the Church and approval to the apostolic endeavours of the juridic person. Like the private association, the temporal goods of the private juridic person are not considered ecclesiastical goods and are administered by the provisions of the statutes. These statutes should also provide norms for the private juridic person in terms of purpose, constitution, membership, and government, etc. Cessation of the private juridic person occurs in ways similar to that of the private association:

through provisions found in the statutes or by the intervention of an ecclesiastical authority if the case warrants it. In terms of advantages and disadvantages regarding the existence of a private juridic person, F. Morrisey states:

A possible advantage to private juridic status is that fewer formalities are involved in transactions and undertakings; so it is easier for those involved to operate according to the civil charter and the Church's general norms for apostolic activities. On the other hand, the private juridic person does not share in the Church's mission as integrally as does the public juridic person, since the private juridic person does not formally act in the name of the Church.²⁴

Like the private association of the faithful, the private juridic person does offer a degree of flexibility in providing an alternative sponsorship model in the health care apostolate. It does indeed offer the possibility of promoting and preserving a Catholic presence in health care. However, to date, only a few health care facilities, systems or groups in the United States have adopted this approach to health care.

C. Public Juridic Person

The model currently gaining in popularity in this country in terms of evolving models of sponsorship and governance is the public juridic person. Among others, the Alberta Catholic Health Corporation, the Catholic Health Sponsors of Ontario, St. Joseph's Health System, Hamilton, ON,

²⁴ F. MORRISEY, "Juridic Status: Canonical Provisions, Possible Applications," in *Health Progress*, 66 (1986) 9, p. 43.

St. Joseph's Health Care Society, London, ON, Fontbonne Health Care Society, Peterborough, ON, and the Chara Health Care Group in British Columbia, have in recent years been established by a formal decree of the competent ecclesiastical authority as public juridic persons of pontifical or diocesan right. This model appears to be gaining support and acceptance as another alternative model in the sponsorship of Catholic health care, thus preserving and promoting the Church's continued presence in the health care area.

Canon 116 provides a definition of the public juridic person by stating that

public juridic persons are aggregates of persons or things which are established by the competent ecclesiastical authority so that, within the limits allotted to them, they might in the name of the Church and in accordance with the provisions of law, fulfill the specific task entrusted to them in view of the public good. Other juridical persons are private.

Public juridic persons are given this personality either by the law itself or by a special decree of the competent authority expressly granting it. Private juridical persons are given this personality only by a special decree of the competent authority expressly granting it.

Becoming a public juridic person is a model that more and more are opting for in order to maintain and promote Catholic character and presence in the health care system due to the factor of its being able to act officially in the name of the Church. As increasing numbers of religious institutes withdraw from the actual ownership and control of health care facilities, the public juridic person

model allows for their legacy to continue in an official way. There are certainly advantages to establishing a public juridic person. To name but a few, the model is structured in such a way as to build into its governance a continuity not dependent on the presence of religious; it is future oriented and promotes lay involvement within the health care system; and, finally, it frees individual religious to pursue other forms of health care activities and roles. Two disadvantages apparent with the public juridic person model of health care sponsorship are the possibility of putting such a new arrangement in the public eye too quickly and, depending on the size of the organization, individual help may not always be readily available for this new model in the event of difficulties and problems. Issues surrounding mission and Catholic identity continue to surface as does the necessity of finding truly qualified lay persons knowledgeable about the public juridic person and mission effectiveness associated with this model of health care.²⁵

III. VARIOUS ROLES INVOLVED IN PRESERVING THE CATHOLIC HEALTH CARE APOSTOLATE

The Catholic health care apostolate, if it is to survive and flourish, needs new structures and new possibilities. Within these new models, various groups and individuals will play key roles. Three categories of persons essential to the health care apostolate will need to come together as partners, collaborators in promoting the Church's essential work of charity in caring for the sick. Significant among these roles will be that of the diocesan bishop, the religious institutes and their members, and

²⁵ CHA, *In Their Own Words*, " p. 16.

of the laity. Each category will have its own duties and responsibilities, but together they will seek to preserve and promote the legacy and witness of the Church in caring for the sick.

A. Role of the Diocesan Bishop

According to the documents of the Second Vatican Council and the 1983 Code of Canon Law, it is the diocesan bishop who recognizes in the particular church entrusted to him the varied apostolates. He is the coordinator of these apostolic works, whether engaged in by clergy, religious or the laity. Nothing should occur in the particular church in regard to the formal apostolate without the knowledge, supervision or blessing of the diocesan bishop.²⁶

In the past, many of the apostolic activities undertaken in a diocese, especially in regard to education and health care, were the sole domain of religious institutes. Invited and encouraged by the diocesan bishop to establish a religious house, the religious lived out their particular charism and apostolic work with little or no interference from the diocesan bishop. Except for those areas calling for his vigilance and supervision, the religious institutes and its members were free to determine what was in the best interest of their particular apostolate. However, with the decline in religious vocations,

²⁶ *CIC 1983*, c. 394, §1: "Varias apostolatus rationes in dioecesi foveat Episcopus, atque curet ut in universa dioecesi, vel in eiusdem particularibus districtibus, omnia apostolatus opera, servata uniuscuiusque propria indole, sub suo moderamine coordinentur." See also VATICAN II, *CD*, n. 17, in *AAS*, 58 (1966), pp. 681-682. (English translation in FLANNERY, vol. 1, pp. 573-574).

aging members and massive changes occurring in health care, the diocesan bishop is being called upon today to act in a more direct manner in order to safeguard and promote the Catholicity of the health care apostolate in the particular church. No discussion concerning the future of the Catholic health care apostolate would be complete today without the involvement of the diocesan bishop.

With new models of sponsorship and governance evolving, he is at the center of promoting and maintaining the Catholic identity of the health care facility. Especially in terms of the evolving model based on the public juridic person, the role of the diocesan bishop is particularly important. It is usually he who grants juridical personality to the health care system or group in his diocese, keeps vigilance over it and receives the annual report of the juridic person. It is the diocesan bishop who determines the Catholicity of a work or institution, watches that temporal goods are being used for intended purposes, and supervises the execution of wills and bequests made to the public juridic person. He may even sit on the Board of Directors of a health care facility or system.

Today, the diocesan bishop has the responsibility of ensuring that the health care apostolate becomes an integral part of the diocesan mission. If he does not do it himself, his duty would be to delegate a qualified person to represent him in health care matters pertaining to this apostolate. The diocesan bishop also has the responsibility to monitor the effectiveness of the *Health Care Ethics Guide*.²⁷ As changes continue to occur in health care throughout the country, his role in the

²⁷ F. MORRISEY, "New Skins? For New Wine," in *CHAC Review*, 21 (1993) 1, p. 12.

preservation of the character, mission, values and philosophy of the Catholic health care apostolate will remain vital to its survival.

B. Role of the Religious Institute and its Members

No discussion on the changing face of health care in this country would be complete without the recognition and inclusion of the vital contribution the various religious institutes in the health care apostolate continue to make. Indeed, their contribution must not be underestimated or devalued. For years they faced countless difficulties and hardships and endured tremendous sacrifices in order to build a solid health care delivery system founded on gospel principles and the fundamental dignity and respect of the human person.

Faced now with declining numbers in North America and rapidly aging communities, many religious institutes are re-evaluating their involvement and association with the health care apostolate. Many of the key positions in administration and nursing once reserved to religious are now being turned over to dedicated and experienced lay people. What is now evolving in the health care apostolate is the whole notion of a shared apostolate, a collaborative ministry between religious and laity in the hope of continuing the legacy of health care founded generations ago. Religious institutes are faced with difficult questions and challenges: do they continue to hold on to what they now have, despite what public legislation is sometimes doing to their institutions; do they adopt new structures and new models or do they change existing ones; and, can they or should they engage in other health

care roles and activities? The Catholic Health Association of the United States makes the following observation, an observation applicable to this country as well as to the United States:

A religious community's strength in the governance of its ministries comes more from who it is and the values that it promotes than from the strictly legal control that it may have regarding a particular institution. This does not deny the existence of or even the need for legal controls. What is more significant than legal control or governance is the success of religious through the years in sponsoring their institutions and in promoting and defending values.²⁸

One thing remains certain, religious institutes and their members will continue to play a special role in the health care apostolate for years to come, though their involvement may take on new expressions.

C. Role of the Laity in the Health Care Apostolate

With the advent of the Second Vatican Council, a renewed ecclesiology became operative as well as a broader understanding of ministry. Vatican II proclaimed that the whole Church, the entire People of God — clergy, religious and laity — were responsible for the proclamation of the gospel. Evangelization and the apostolate were no longer the exclusive domain of a few in the Church. The Council called for a greater participation and collaboration in all facets of Church life. This resulted in the laity being empowered to live out in a more direct way their baptismal vocation.

In the health care apostolate today the laity are emerging into areas of greater participation

²⁸ CHA, *The Search for Identity*. p. 74.

in administration, sponsorship, governance and in some cases even ownership of Catholic health care facilities. Their expertise and experience combined with their dedication are allowing the laity to assume a partnership role in the advancement of Catholic health care. Though highly qualified in their fields of expertise, the need exists today — if this is to continue to be a truly Catholic work — for lay persons to become educated and qualified in the whole area of health care ethics.

IV. THE FUTURE OF THE CATHOLIC HEALTH CARE APOSTOLATE IN NEW BRUNSWICK

Today, Catholic involvement in health care in New Brunswick, like so many other areas, faces an unknown and uncertain future. The apostolate is being challenged to reassess its role and presence in society. There are significant moves today from healing to health, from institutions to persons, and from curing to preventive health care.

In 1992, government legislation nearly extinguished church involvement in the provincial health care system. Reaction to government policies on the part of the New Brunswick Catholic Health Association, the various religious institutes and others brought about provisions allowing some degree of participation and presence in the delivery of health care in New Brunswick. After considerable discussions and negotiations, the establishment of Advisory Committees for each of the

Catholic hospitals in the Province would preserve and enhance the Catholicity of those facilities. At the same time, one of the important issues not satisfactorily resolved, even to this day, was the whole question of equity.²⁹

This section of chapter four will focus on the present situation of the Catholic health care apostolate in New Brunswick. At the same time, some possibilities regarding future involvement in health care will be put forward in the hopes of maintaining an active Catholic presence in health care in the Province for years to come.

A. The Present Situation of Catholic Health Care in New Brunswick

Traditionally, Catholic health care has been identified with ownership and administration of facilities, governed by a board of directors. This certainly has been the case in New Brunswick for decades. Religious institutes have played a prominent role in the development of the Province's health care network. This is rapidly changing. Today, in New Brunswick, as elsewhere, health care is no longer just the domain of religious institutes and its members. Throughout the

²⁹ H. BLACK, *Black's Law Dictionary*, on p. 540 defines equity as being "a stockholder's proportionate share (ownership interest) in the corporation's capital stock and surplus. The extent of an ownership interest in a venture. In this context, equity refers not to a legal concept but to the financial definition that an owner's equity in a business is equal to the business's assets minus its liabilities." It also states that equity is the "value of property or an enterprise over and above the indebtedness against it (e.g., market value of house minus mortgage)."

country, Catholic health care is looking for new models whereby its presence and involvement will be maintained and enhanced. Furthermore, acute care facilities such as hospitals are no longer being viewed as the only form of involvement of church groups in the delivery of health care. A shift has been occurring away from active, acute care facilities to new areas covering community health, long term care, and even home health care. New areas of concern are developing and new frontiers awaiting to be explored as the Catholic health care apostolate stands at the threshold of a new period in its history. The last century in New Brunswick Catholic health care witnessed religious institutes responding to a unique situation. The same holds true in this time of transition and transformation.

With all the rapid and dramatic changes taking place in health care in New Brunswick, there appear to be two alternatives for the Catholic health care apostolate. First, formal involvement in the delivery of health care can be forfeited, thus ending a long association of leadership and witness in the Province. This should not be allowed to happen if at all possible. The call and mandate of the gospel to heal the sick remain as strong today as ever in the Church and in society. Catholic health care must stay attuned to the needs and challenges waiting to be addressed and acted upon, using all the tools and resources at its disposal to continue an active association and presence in health care. Second, attempts to resist change of any kind can be taken — thereby denying the necessity of much needed change and reform of the health care system in the Province. Catholic health care has always been in the forefront of developing new methods and responding to new challenges in caring for the

sick. The time has come once again to be pioneers in order to develop new approaches in health care where Catholic mission, values, philosophy and ethics are upheld in a world of depersonalization, technological advances and economic greed.

B. Areas Needing to be Addressed

In terms of the future of the Catholic health care apostolate in New Brunswick, a number of areas need to be addressed. Those involved in Catholic health care have to come to terms with the changes and re-alignment taking place in health care, both nationally and provincially. The escalating costs and distribution of health care called for dramatic changes. The changes that came about in 1992 mostly likely cannot be undone. The time has come to move on and continue in faith-filled ways to care for the sick and suffering. Catholic health care in New Brunswick needs to examine closely its active participation in acute health care and determine whether or not this is the way of the future.

One of the areas already mentioned and yet to be resolved by the Letter of Understanding and the Agreement of 1993 is the question of the equity of the Catholic hospitals. While it is true that substantial sums of public funds have, over the past thirty years, been forwarded to these health care institutions, the fact remains that for the most part religious institutes bore the cost of constructing these facilities. In addition, for decades, often under difficult circumstances, costs of equipment, salaries, repairs, education, etc., were borne by the religious institutes. Those religious who staffed

these facilities worked under trying conditions and received little if anything for the services they rendered. Everything was put back into the running of the health care institution. While today government funding looks after construction and renovations of hospital facilities, salaries, equipment, etc., what about the many, many years the religious institutes and their members provided for the health care needs of the general populace out of their own pockets? This important matter calls out for a just and equitable solution and settlement, one that is satisfactory to all parties involved. Both government and religious institutes need to enter into frank discussions and mutually come to some agreement on this question of equity. Perhaps the terms found in other agreements between governments and religious institutes elsewhere could serve as a guide to the New Brunswick scene. One of the first things that should already be in place beforehand if and when the government agrees to an equity settlement, are up-to-date inventories, providing all the necessary and relevant data.

C. New Dimensions For Catholic Health Care in New Brunswick

What lies ahead for the Catholic health care apostolate in New Brunswick? Opportunities abound for an active Catholic health care apostolate in the Province — an apostolate based on gospel values and long established moral principles. With debate raging over ethical issues such as abortion, genetic engineering, cloning, and assisted suicide, a golden opportunity awaits the leadership and witness of Catholic health care values and philosophy. In New Brunswick, the Catholic health care apostolate is in an ideal position to influence government policy regarding an increase in

the number of beds allotted for the elderly and continued quality care for these vulnerable seniors. Two other important and significant areas calling out for Catholic health care involvement would be the care of Alzheimer's patients and the terminally ill. Those afflicted with the dreaded and debilitating disease of Alzheimer's cry out for compassionate and quality care. Again, the Catholic health care apostolate in the Province could influence government and health authorities in establishing centers specifically designed for this purpose.³⁰ Furthermore, palliative care centres for those facing terminal illness need to be established in the Province. In the face of proposals to allow assisted suicide, Catholic health care could continue in a more direct way by proclaiming that life is not expendable at any cost. One of the values of the Catholic health care apostolate is its respect for human life at all stages. What better way to proclaim that message than acting as advocates in seeing that holistic care, support and compassion are made available to the terminally ill and their families.

In addition to what already has been discussed, health care reform today involves a new venture — the whole idea of home health care. This offers the Catholic health care apostolate another opportunity to provide its expertise and assistance. It could take the initiative in further developing the potential of this new health care program in the years ahead. As care of the sick moves from the hospital facility back into the home, the Catholic health care apostolate could exercise a leadership role in this original type of health care. Likewise, the possibility exists for sponsoring centres

³⁰ Construction has already begun on an Alzheimer's unit attached to Rocamura Nursing Home, owned and administered by the Sisters of Charity of the Immaculate Conception. The Sisters have contributed \$800,000.00 to the unit, while the remainder of the funds are being raised through private and corporate donations. No government funding is assisting this project.

specializing in promoting wellness and preventive medicine. The on-going promotion of parish nurses could be an excellent initiative. These persons could provide assistance to those who have recently been released from hospital, etc.

From ownership and administration in acute health care in New Brunswick, the Catholic health apostolate stands at the crossroads of new horizons and possibilities. With its resources, experience and expertise, in terms of influence, advocacy and sponsorship in health care, there lie riches waiting to be tapped into. In shifting the focus from the traditional involvement in caring for sick, the Catholic health care apostolate in New Brunswick can be a stable force in proclaiming the sacredness of life and respect for human dignity; in this way the basic right to quality health care of all citizens is upheld. The Catholic health apostolate in this Province is in a privileged position to exert more influence and pressure on government and health care authorities to guarantee the kind of quality care its citizens deserve.

D. Canonical Models for the Catholic Health Care Apostolate in New Brunswick

To preserve and enhance the Catholic health care apostolate in New Brunswick, two areas need further study and discernment. First, how best to carry on the mandate of the gospel in regard to healing the sick? The time has come in the Province where those involved in Catholic health care

must see themselves as partners and collaborators, not as competitors. In order to maintain a Catholic presence in the health care system in the future, consideration could be given to the establishment of a Catholic Health Care Society, similar to those found in Alberta and Ontario. All Catholic health care facilities such as hospitals, nursing homes, clinics, hospices, long-term care centres, etc., could come together under the umbrella of this Society. In order to strengthen and enhance its presence as an official apostolate of the Church, this Society could be canonically established as a public juridic person. It could be interdiocesan or provincial in nature and fall under the competency of an interdiocesan authority, such as the ecclesiastical province. Establishment of this Catholic Health Care Society as a public juridic person would allow the legacy of the religious institutes involved in health care to continue for years to come. Consideration could also be given to the possibility of appointing an Episcopal Vicar for health care in each New Brunswick diocese. This would bring to the forefront the importance of the health care apostolate in the particular church and the involvement to which all are called in caring for the sick.

Secondly, there exists a necessity to educate and inform the laity in New Brunswick about their baptismal responsibility and the role they can play in Catholic health care. Many lay persons have the sincere desire to serve in this apostolate and they possess the skills, enthusiasm and dedication to be part of a new approach in living out this work of charity. Already lay people serve in many capacities — as administrators, nurses, pastoral care workers, members of regional hospital corporation boards — they need to be empowered to do more, especially in the field of medical ethics. This is their opportunity to animate the temporal order with the message of the gospel. This

vital resource needs to be encouraged if the Catholic health care apostolate is to continue to be a thriving part of the provincial health care scene in the years ahead. This is an area where co-operation between the New Brunswick Catholic Health Association, the religious institutes and the bishops could take place so that a greater lay participation in this essential and integral work of the Church, could continue. Bursaries should be provided for lay people to study ethics and other related subjects if our health care is to remain a Catholic work based on informed moral decisions.

CONCLUSION

Chapter Four has examined the evolving models that have developed and continue to be developed in Catholic health care throughout the country at the present time. With the dramatic changes occurring in the way health care is perceived and delivered, these models can certainly help to achieve and guarantee a Catholic presence in the future of this essential work of charity in the Church.

Moreover, the chapter has examined the canonical possibilities that can assist in the preservation of Catholic health care — the association of the Christian faithful, the private juridic person and the public juridic person. Within the parameters of canon law, there lies enough flexibility to adopt a variety of models in order to maintain the character, mission, values and philosophy found in this apostolate. Likewise, canon law provides directives regarding the various roles necessary in preserving church involvement in the future.

Finally, Chapter Four has provided thoughts on the future of the Catholic health care apostolate in New Brunswick. The areas discussed have dealt with the present situation in light of government legislation; areas still needing to be addressed and dealt with; new areas for Catholic health care in the future; and, one of the canonical models available to retain an active presence in the health care system in the Province.

Although the canonical status of the Catholic health care apostolate in New Brunswick has been altered in the broadest sense of the term, nevertheless, there remains a definite place in providing care for the sick in new forms as well as the more traditional ones. Canon law is at the service of the Church and it provides enough flexibility and creativity so as to protect and preserve this essential work which touches the very mission of the Church itself — a mission that cannot be usurped, denied or forfeited.

GENERAL SUMMARY AND CONCLUSION

Canon law speaks of the right to exercise the mission of the Church by involvement in works of the apostolate and works of charity and by permeating the temporal order with the message of the gospel.¹ Certainly one of those works of the apostolate and charity is the care of the sick. Held in such high esteem, care for and healing of the sick can be considered an integral and essential part of the Church's mission. Given as a command of the Lord himself, the Church has for centuries remained faithful and steadfast in providing facilities imbued with gospel principles, with care and compassion in treating those afflicted with illness of one kind or another.

From its very beginning, the mandate given to the Church "to heal the sick," has been expressed in a variety of ways. The most visible and tangible manner has been the establishment of health care facilities. In this country, these facilities range from hospitals, clinics, hospices, to homes for the aged and extended care. They have been centres of excellence, dedication and unselfish service. In New Brunswick, responding to the needs of the day, religious institutes of women set out in the last century to care for victims of disease and for an influx of immigrants to the Province. From that beginning, these religious laid the foundation for the development of a highly complex and sophisticated health care system. For well over a hundred years, despite all hardships and difficulties, religious institutes played an invaluable role in undertaking, as part of their mission in the Province, the care of the sick. Their contributions, both in terms of personnel and material support, cannot be downplayed or forgotten. These pioneers envisioned the importance and necessity of a healthy population and society, and ventured to promote and enhance this by establishing and administering

¹ *CIC 1983*, c. 298, §1

high quality health care centres in all regions of the Province. Their direct involvement in the health system in New Brunswick is a lasting legacy of faith, zeal, dedication, compassion and stamina. They made visible, in a concrete manner, the mandate of the gospel. They have aligned themselves with the most vulnerable members of society — the sick, the suffering, the frail, the unwanted —and made this mission of charity part and parcel of their very reason for existing as a religious institute. To deprive these institutes and their members of this integral work of the Church would be quite drastic.

Canon 1254 states that the Church has the right to acquire, retain, administer and alienate temporal goods. In determining the canonical status of Catholic health care facilities in New Brunswick in the light of recent provincial government legislation, it becomes necessary to examine certain juridical concepts and principles. Three categories are involved: canonical legislation pertaining to the notion of juridical personality, ecclesiastical ownership of property and goods, and the matter of Catholic identity as it relates to health care facilities.

By applying these canonical principles to Catholic health care facilities in New Brunswick, it can be concluded, first, that these facilities have been attached to the religious institutes founding them. These institutes are classified in the Church as public juridic persons by the law itself. The health facilities established by these institutes share in the juridical personality of the religious institute. The Catholic health care facilities in New Brunswick act in the name of the Church and on behalf of the Church. They represent the best of what the Catholic Church stands for in terms of the sacredness of human life, respect for the dignity of the human person, and providing for the spiritual

needs of those entrusted to them for care, treatment and healing. By sharing in the juridic personality of the religious institutes founding them, these facilities have the right to acquire, retain, administer and alienate temporal goods to carry out their mission of health care.

Second, in regard to ecclesiastical property and goods, canon law stipulates that only the public juridic person can acquire, retain, administer and alienate temporal goods. This property and goods of Catholic health care facilities in New Brunswick have been acquired through various sources and administered over the years according to the canonical discipline governing the administration of property and goods. Furthermore, this property and these goods have been given protection in civil law by means of incorporation. There can be no doubt that Catholic health care facilities in New Brunswick are ecclesiastical entities, with rights and obligations.

In March 1992, the government of New Brunswick, through legislation, took control of the administration of the Catholic hospitals in the Province. No action was ever taken by the lawful owners of these facilities to cede ownership of their hospitals to the Province. Therefore, in terms of alienation of ecclesiastical property and goods, the canonical status, strictly speaking, has not changed. However, in a broad sense of the meaning of alienation, the Catholic hospitals were placed in jeopardy by the Hospital Act of 1992. The full right of ownership — which includes acquisition, retention, administration and alienation of property and goods — has been reduced and restricted. In that sense, then, the canonical status of these institutions has certainly been altered. Though the land and buildings continue to be owned by the religious institutes, the carrying out of the administration by the owner was denied by the government and placed in the hands of another entity created by provincial legislation. Furthermore, the terms of the Letter of Understanding and

Agreement of 1993 calling for the signing of leases for each Catholic hospital in the Province, challenge the Catholicity of these institutions.

The third factor considered in determining canonical status focused on the notion of Catholic identity. Based on an institutional model of ecclesiology, there can be no denying the “Catholicity” of these hospitals in New Brunswick. They have been owned, administered and staffed by large numbers of religious for years. These facilities have been perceived by government, ecclesiastical authorities and the general populace as being Catholic both in name and nature. Catholic teachings have been upheld and have permeated these facilities from the very beginning of their establishment in the Province. Pastoral care has been under the direction of the diocesan bishops — chaplains have been appointed, chapels erected, public worship celebrated and spiritual needs provided. Above all, these facilities and the mission carried out have attested to the very presence of Christ in the midst of sickness, pain and suffering. Though the above-mentioned activities are still present to some extent in these facilities, these, too, are changing as some active, acute care facilities are developing into specialized clinics. However, provisions already have been established which uphold the mission, values, philosophy and ethics associated with Catholic health care facilities in New Brunswick. Through the creation of Advisory Committees for each Catholic hospital in the Province, the door remains open to continuing Catholic participation in the health care system. Every opportunity to develop the full potential of these Committees must be seized so that the long legacy of Catholic involvement in health care continues in the future.

Another factor in the determination of the canonical status of Catholic health care facilities in New Brunswick revolved around an analysis of pertinent civil legislation. The Catholic contribution to health care in the Province, on the part of those religious institutes who continue to own health

care facilities, has been invaluable. By announcing the revamping of the health care system in New Brunswick, especially hospital facilities, the Minister of Health and Community Services virtually terminated that long tradition of involvement. The Hospital Act of 1992 prohibited religious institutes and their members from operating their own hospitals as well as providing hospital services anywhere in the Province. By examining events leading up to this legislation and the legislation itself, it can clearly be seen that the status of these institutions has been altered. By this legislation, the owners of the seven Catholic hospitals lost the administration and control of their own facilities. However, after considerable reaction by the New Brunswick Catholic Health Association, the religious owners, the bishops and citizens, negotiations eventually led to the amendment of the Hospital Act of 1992. The amendment allowed the Catholic hospitals to continue operating in the Province. The prime motivation behind the sudden change appears to have been the threat of a Supreme Court challenge, centered on an alleged violation of the Charter of Rights and Freedoms. Finally, the establishment of the already mentioned Advisory Committees would become the new model for preserving and promoting the Catholic character and mission of health care in New Brunswick. The possibilities associated with these Committees need to be explored and their full potential developed if the Catholic presence in health care is to survive into the next century.

Finally, what does the future hold in store for Catholic health care in general and, more specifically, in the Province of New Brunswick? One thing is certain, the health care system is in the process of being transformed and reshaped in all regions of the country. In the past, many of the apostolates in the Church, including health care, were seen as the domain of religious institutes and their members. However, due to both external and internal factors, this no longer remains the case. Alternative forms of exercising the health care apostolate are presently being studied and

implemented. This remains essential if a Catholic involvement in health care is to remain a vital and viable component in the health care system. Changes in the way health care is perceived and carried out dictate a need for new structures and new opportunities to enhance its mission and purpose. These possibilities need to be seriously considered in order to guarantee that the Catholicity of the health care facility remains intact and relevant in the future.

Canon law offers the flexibility and creativity to adapt to new models in order to maintain the character and mission of the Catholic health care apostolate. What is needed now is vision and courage to embrace what lies ahead for this integral part of the Church's mission. New dreams and new challenges await all those involved in continuing the legacy, begun long ago, of caring for and healing the sick. Catholic involvement in health care is vital and necessary in society and every measure needs to be employed in order to protect and promote its existence and continuation.

By way of conclusion then, the following points can be derived from this dissertation. They are as follows:

1- Church involvement in health care dates back to gospel times. In the face of disease and illness, Christians have responded in a concrete way with providing care, treatment and compassion. The most notable manner in which they have done so has been to establish facilities such as hospitals, clinics, homes for the aged, schools of medicine and nursing, etc. Health care has been and continues to be a vital part of the mission of the Church and a fulfilment of Christ's command "to heal the sick." In addition, many religious institutes were founded with the mission of caring for the sick. This

apostolate is constitutive of their very reason for existing. To deprive them of this charism amounts to an assault on their character and strikes at the core of their survival.

2- Since 1868 religious institutes of women have been directly involved in the delivery of efficient, high quality health care in the Province of New Brunswick. They have heeded the challenge to come to this Province in response to the needs of the time. Their contribution to the health care system remains highly significant and invaluable. These institutes and their members have responded to the apostolate of caring for and healing the sick by establishing, owning, administering and staffing health care facilities in all regions of the Province. These facilities have a tremendous impact on the whole health care system of New Brunswick. Without them, a void would certainly exist in the way care and treatment are given to those afflicted by sickness.

3- In determining the canonical status of Catholic health care facilities in New Brunswick, a number of canonical principles have been examined. These have a direct effect on that status at the present time. It can be concluded that Catholic health care facilities in New Brunswick are ecclesiastical entities, founded, established and owned by religious institutes who have included in their proper law care of the sick as one of the basic works to be engaged in by their members. These health care facilities have been constructed and financed by vast amounts of funds belonging to these religious institutes. In addition, the facilities have been administered and, until recently, staffed by religious. They have been, and continue to be, perceived as Catholic institutions, following the mission, values, philosophy and ethics of the health care apostolate; pastoral care has been an essential element of these facilities.

4- By examining the civil legislation as contained in the Hospital Act of 1992, though religious institutes continue the ownership of the Catholic hospitals in New Brunswick as far as land and buildings are concerned, the government has assumed the actual control and administration of these facilities, placing that administration in the hands of a Regional Hospital Corporation. Their very *raison d'être* and identity has been jeopardized and threatened by this legislation. Strictly speaking, since ownership of the land and buildings of the remaining Catholic hospitals in the Province has not been ceded to the government by lawful means, their status in that sense remains the same. However, in the broad sense of the term, a definite alienation of ecclesiastical property and goods has occurred resulting in a change in the canonical status of the Catholic hospitals in New Brunswick. Furthermore, replacement of the individual Catholic hospital boards with regional hospital corporations means that the administration and control of these facilities has been placed elsewhere. Could it be possible that this apostolate of the religious institutes in New Brunswick has also been lost?

5- Despite much opposition to their legislation implementing reform in the health care system in the Province, government officials did not deviate from their planned policies. However, after considerable reflection and negotiation, a compromise solution was reached between the New Brunswick Catholic Health Association, the religious owners of hospital facilities and the Province of New Brunswick. In a subsequent Letter of Understanding and Agreement dated April 21, 1993, the Hospital Act of 1992 was amended to allow hospitals to be owned by religious groups in the Province. The administration of these facilities would remain the domain of the regional hospital corporations. At the same time, in order to preserve the "Catholicity" of the religious hospitals in the Province, Advisory Committees were established for each facility. These committees would safeguard the character and mission of the facilities and ensure that they would remain intact. A new model for Catholic health care was fast developing in the Province.

6- Finally, although the canonical status of Catholic hospitals in New Brunswick has been altered in the light of the 1992 provincial government legislation, there remains a privileged position in the health care system for Catholic involvement and participation. While those responsible for this apostolate continue to permeate the hospitals still under their ownership with the Catholic mission, values, philosophy and ethics, other areas in the apostolate await their further involvement.

It must be acknowledged that the canonical status of the Catholic hospitals in New Brunswick has been definitively altered by the provincial government legislation of 1992. However, other Catholic health care facilities continue to be owned, administered and controlled by religious institutes in New Brunswick. These facilities, coming together as one single entity in a spirit of collaboration and partnership and with the continued involvement of the diocesan bishops and the dedicated laity in the Province, can continue to make visible and tangible the very presence of the Healing One who issued the command nearly two thousand years ago “to heal the sick.”

To actualize this command, in recognizing the steadfast faith, zeal, dedication and witness of the many religious women involved since 1868 in Catholic health care in New Brunswick, it is recommended that attempts be fostered to continue their legacy well into the future. Despite existing external and internal forces facing the Catholic health care apostolate, there remains a rightful place in society for this work of charity, this integral mission of the Catholic Church.

Canon law provides the necessary provisions to assist in this endeavour. Catholic health care facilities need to come together and form a partnership, an alliance in order to preserve and promote active participation in the health care system in New Brunswick. By becoming a public juridic person, a New Brunswick Catholic Health Care Society would be officially recognized and approved by the

competent ecclesiastical authorities. It would officially act in the name of and on behalf of the Church in the area of health care in the Province. Furthermore, a Catholic Health Care Society comprised of hospitals, nursing homes, clinics, hospices, etc., would strengthen and enhance the presence and influence of the Catholic health care apostolate in the Province. This new and evolving model has been implemented in other areas of the country and the time has surely come to contemplate bringing it into existence in New Brunswick for the continued preservation and promotion of Catholic involvement in caring for and healing the sick — an indispensable part of the Church's mission.

APPENDIX A

BILL 23

AN ACT TO AMEND THE PUBLIC HOSPITALS ACT

1st Session, 52nd Legislature
New Brunswick
41 Elizabeth II, 1992

1^{re} session, 52^e législature
Nouveau-Brunswick
41 Elizabeth II, 1992

BILL # 23

PROJET DE LOI

**AN ACT TO AMEND THE
PUBLIC HOSPITALS ACT**

**LOI MODIFIANT LA
LOI SUR LES HÔPITAUX PUBLICS**

HON. RUSSELL H.T. KING

L'HON. RUSSELL H.T. KING

1992

An Act to Amend the Public Hospitals Act

Her Majesty, by and with the advice and consent of the Legislative Assembly of New Brunswick, enacts as follows:

1 *The Public Hospitals Act, chapter P-23 of the Revised Statutes, 1973, is amended by adding after section 17.32 the following:*

17.33(1) Effective April 1, 1992, the Minister has, without further action, the control and management of the business and affairs of the following bodies corporate as the business and affairs relate to hospitals and hospital services:

- (a) THE ALBERT COUNTY HOSPITAL INC.;
- (b) Northern Carleton Hospital;
- (c) FUNDY HOSPITAL ASSOCIATION, LIMITED;
- ~~(d)~~ Campobello Health Centre;
- (e) East Restigouche Community Health Care Centre;
- (f) Upper Miramichi Health Centre;

Loi modifiant la Loi sur les hôpitaux publics

Sa Majesté, sur l'avis et du consentement de l'Assemblée législative du Nouveau-Brunswick décrète:

1 *La Loi sur les hôpitaux publics, chapitre P-23 des Lois révisées de 1973, est modifiée par l'ajonction après l'article 17.32 de ce qui suit:*

17.33(1) À partir du 1^{er} avril 1992, le Ministre sans autres formalités, le contrôle et la gestion l'activité et des affaires internes des corps constitués suivants en autant que l'activité et les affaires internes se rapportent aux hôpitaux et aux services hospitaliers:

- a) THE ALBERT COUNTY HOSPITAL INC.;
- b) Northern Carleton Hospital;
- c) FUNDY HOSPITAL ASSOCIATION, LIMITED;
- d) Campobello Health Centre;
- e) Centre communautaire de santé de Restigouche-est;
- f) Upper Miramichi Health Centre;

nn

(g) Health Services Centre, Village of Fredericton Junction;

(h) THE GRAND MANAN HOSPITAL, LIMITED;

(i) Harvey Community Hospital;

(j) Hôpital de Lamèque;

(k) MacLean Memorial Hospital;

(l) Queens North Hospital;

(m) Centre de Santé - Paquetville;

(n) Petitcodiac Health Centre;

(o) The Tobique Valley Hospital;

(p) Health Services Centre, Rexton;

(q) Rogersville Health Centre;

(r) L'HOTEL-DIEU SAINT-JOSEPH DE SAINT-QUENTIN INC.;

(s) L'Hôpital Stella Maris de Kent;

(t) Regional Medical Centre, Shediac;

(u) Health Services Centre, Village of Stanley;

(v) L'HOPITAL DE L'ENFANT-JESUS INC.;

(w) Religious Hospitallers of St. Joseph of Chatham, N.B.;

(x) Hopital St. Joseph de Dalhousie;

(y) FOREST HILL REHABILITATION CENTRE INC.;

(z) GRAND FALLS GENERAL HOSPITAL INC. - L'HOPITAL GENERAL DE GRAND SAULT INC.;

(aq) The Miramichi Hospital;

(bb) Oromocto Public Hospital;

(cc) L'HOTEL-DIEU SAINT-JOSEPH DE PERTH-ANDOVER INC.;

(dd) The Sackville Memorial Hospital;

g) Centre de soins médicaux, Village de Fredericton Junction;

h) THE GRAND MANAN HOSPITAL, LIMITED;

i) Harvey Community Hospital;

j) Hôpital de Lamèque;

k) MacLean Memorial Hospital;

l) Queens North Hospital;

m) Centre de Santé - Paquetville;

n) Petitcodiac Health Centre;

o) The Tobique Valley Hospital;

p) Health Services Centre de Rexton;

q) Centre de santé de Rogersville;

r) L'HOTEL-DIEU SAINT-JOSEPH DE SAINT-QUENTIN INC.;

s) L'Hôpital Stella Maris de Kent;

t) Centre médical régional de Shédiac;

u) Centre de soins médicaux, Village de Stanley;

v) L'HOPITAL DE L'ENFANT-JESUS INC.;

w) Religious Hospitallers of St. Joseph of Chatham, N.B.;

x) Hopital St. Joseph de Dalhousie;

y) FOREST HILL REHABILITATION CENTRE INC.;

z) GRAND FALLS GENERAL HOSPITAL INC. - L'HOPITAL GENERAL DE GRAND SAULT INC.;

aa) The Miramichi Hospital;

bb) Oromocto Public Hospital;

cc) L'HOTEL-DIEU SAINT-JOSEPH DE PERTH-ANDOVER INC.;

dd) The Sackville Memorial Hospital;

(ee) ST. JOSEPH'S HOSPITAL, SAINT JOHN, N.B.;

(ff) The Charlotte County Hospital;

(gg) Sussex Health Centre;

(hh) L'HOTEL-DIEU SAINT-JOSEPH DE TRACADIE INC;

(ii) Hôpital de Tracadie;

(jj) THE CARLETON MEMORIAL HOSPITAL;

(kk) Chaleur Regional Hospital;

(ll) Campbellton Regional Hospital;

(mm) Edmundston Regional Hospital;

(nn) Dr. Everett Chalmers Hospital;

(oo) Doctor Georges L. Dumont Hospital;

(pp) The Moncton Hospital; and

(qq) Saint John Regional Hospital.

17.33(2) Effective April 1, 1992, all rights, powers, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the boards of the bodies corporate listed in subsection (1) that relate to hospitals and hospital services are, without further action, transferred to and vested in the Minister.

17.33(3) Effective April 1, 1992, and despite anything in any other Act of the Legislature, in regulations under an Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the Minister constitutes a one-person board of each of the bodies corporate listed in subsection (1) and may constitute a meeting of the board with respect to matters that relate to hospitals and hospital ser-

ee) ST. JOSEPH'S HOSPITAL, SAINT JOHN, N.B.;

ff) The Charlotte County Hospital;

gg) Sussex Health Centre;

hh) L'HOTEL-DIEU SAINT-JOSEPH TRACADIE INC;

ii) Hôpital de Tracadie;

jj) THE CARLETON MEMORIAL HOSPITAL;

kk) Hôpital régional Chaleur;

ll) Hôpital régional de Campbellton;

mm) Hôpital régional d'Edmundston;

nn) Hôpital Dr Everett Chalmers;

oo) Hôpital Docteur Georges L. Dumont;

pp) The Moncton Hospital; et

qq) Hôpital régional de Saint-Jean.

17.33(2) À partir du 1^{er} avril 1992, tous droits, tous les pouvoirs, toutes les fonctions, toutes les responsabilités des conseils des corps constitués énumérés au paragraphe (1), qui soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux hôpitaux et aux services hospitaliers sont, sans autres formalités, transférés et dévolus au Ministre.

17.33(3) À partir du 1^{er} avril 1992, et nonobstant quoi que ce soit dans toute autre loi de la Législature, dans les règlements établis en vertu d'une loi de la Législature, dans les statuts constitutifs, dans les lettres patentes, dans les règlements administratifs ou dans tout autre document ou instrument, le Ministre constitue un conseil d'un administrateur unique de chacun des corps constitués énumérés au paragraphe (1) et il peut constituer une réunion de ces conseils.

17.33(4) Effective April 1, 1992, the Minister may exercise any and all of the rights and powers and may discharge any and all duties and responsibilities that may be exercised or discharged by the boards of the bodies corporate listed in subsection (1) that relate to hospitals and hospital services.

17.33(5) Effective April 1, 1992, and without limiting the generality of subsections (1), (2), (3) and (4), the Minister may enter into agreements or arrangements with financial institutions with which the boards of the bodies corporate listed in subsection (1) dealt in order to permit and continue the transaction of the financial affairs of the bodies corporate as the financial affairs relate to hospitals and hospital services.

17.33(6) Effective April 1, 1992, the persons who were members of the boards of the bodies corporate listed in subsection (1) on March 31, 1992 shall not exercise or discharge any of the rights, powers, duties or responsibilities of members of those boards that relate to hospitals or hospital services.

17.33(7) Effective April 1, 1992, and despite any other Act of the Legislature, any regulations under any Act of the Legislature, any articles of incorporation, letters patent, by-laws or other document or instrument, the Minister may appoint officers of the bodies corporate listed in subsection (1), and upon such appointments, without further action, the rights, powers, duties and responsibilities, whether established by an Act of the Legislature, regulations under an Act of the Legislature, articles of incorporation, letters patent, by-laws or other document or instrument, of the officers of the bodies corporate that relate to hospitals and hospital services are transferred to, vested in, and may be exercised or discharged by, the officers appointed by the Minister.

17.33(4) À partir du 1^{er} avril 1992, le Ministre peut exercer l'un et l'ensemble des droits et pouvoirs et il peut exécuter l'une et l'ensemble des fonctions et des responsabilités qui peuvent être exercés ou exécutées par les conseils des corps constitués énumérés au paragraphe (1) se rapportant aux hôpitaux et aux services hospitaliers.

17.33(5) À partir du 1^{er} avril 1992, et sans limiter la portée des paragraphes (1), (2), (3) et (4), le Ministre peut conclure des accords ou arrangements avec les institutions financières avec lesquelles les conseils des corps constitués énumérés au paragraphe (1) ont conclu des affaires afin de permettre et de continuer la conclusion des opérations financières des corps constitués selon que les opérations financières se rapportent aux hôpitaux et aux services hospitaliers.

17.33(6) À partir du 1^{er} avril 1992, les membres des conseils des corps constitués énumérés au paragraphe (1) le 31 mars 1992 ne peuvent exercer ou exécuter aucun des droits, pouvoirs, fonctions ou responsabilités des membres de ces conseils se rapportant aux hôpitaux ou aux services hospitaliers.

17.33(7) À partir du 1^{er} avril 1992, et nonobstant toute autre loi de la Législature, tous règlements établis en vertu d'une loi de la Législature, de tous statuts constitutifs, de toutes lettres patentes, de tous règlements administratifs ou de tous autres documents ou instruments, le Ministre peut nommer des dirigeants des corps constitués énumérés au paragraphe (1), et dès que ces nominations sont faites, sans autres formalités, les droits, les pouvoirs, les fonctions et les responsabilités des dirigeants des corps constitués se rapportant aux hôpitaux et aux services hospitaliers, qu'ils soient établis par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par d'autres documents ou instruments, sont transférés et dévolus aux dirigeants nommés par le Ministre et peuvent être exercés ou exécutés par ces dirigeants.

17.33(8) Effective April 1, 1992 and until the rights, powers, duties and responsibilities transferred to and vested in the Minister, or officers appointed by the Minister, under this section terminate, any reference in an Act of the Legislature, in regulations under an Act of the Legislature, in articles of incorporation, letters patent, by-laws or any other document or instrument to the board or officers of the bodies corporate listed in subsection (1) shall, as it relates to hospitals and hospital services, be read as a reference to the Minister or to officers appointed by the Minister, as the case may be.

17.33(9) The control and management by the Minister of the business and affairs of the bodies corporate listed in subsection (1), as the business and affairs relate to hospitals and hospital services, and the rights, powers, duties and responsibilities transferred to and vested in the Minister or officers appointed by the Minister under this section, or acquired by the Minister or the officers in the exercise or the discharge of the rights, powers, duties and responsibilities under this section, terminate at the end of June 30, 1992 or at the end of such earlier date as is fixed by the Lieutenant-Governor in Council.

17.33(10) This section supersedes the *Expropriation Act*.

17.33(11) No action, application or other proceeding lies or shall be instituted against the Minister or the Crown in right of the Province in respect of any thing done, or omitted to be done, under this section in relation to hospitals or hospital services.

17.33(12) Without restricting the generality of subsection (11), no action for dismissal, whether express, implied or constructive, lies or shall be instituted against the Minister or the Crown in right of the Province in respect of any transfer or vesting of rights, powers, duties or responsibilities under this section.

17.33(8) À partir du 1^{er} avril 1992 et jusqu'à que cessent les droits, les pouvoirs, les fonctions, les responsabilités transférés et dévolus en vertu du présent article au Ministre, ou aux dirigeants nommés par le Ministre, les renvois dans toute loi de la Législature, dans tous règlements établis en vertu d'une loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument au conseil ou aux dirigeants des corps constitués énumérés au paragraphe (1) doivent, en ce qu'ils se rapportent aux hôpitaux et aux services hospitaliers, s'entendre de renvois au Ministre ou aux dirigeants nommés par le Ministre, selon le cas.

17.33(9) Le contrôle et la gestion par le Ministre de l'activité et des affaires internes des corps constitués énumérés au paragraphe (1), en autant qu'elles se rapportent aux hôpitaux et aux services hospitaliers et, également, les droits, pouvoirs, fonctions et responsabilités transférés et dévolus au Ministre ou aux dirigeants nommés par le Ministre en vertu du présent article, ou acquis par le Ministre ou les dirigeants dans l'exercice ou l'exécution des droits, pouvoirs, fonctions et responsabilités en vertu du présent article, cessent à l'expiration du 30 juin 1992 ou à l'expiration de la date la plus rapprochée fixée par le lieutenant-gouverneur en conseil.

17.33(10) Le présent article a priorité sur la *Loi sur l'expropriation*.

17.33(11) Nulle action, demande ou autre procédure n'existe ni ne peut être engagée contre le Ministre ou la Couronne du chef de la province à l'égard de toute chose qui est faite, ou omise, en vertu du présent article relativement aux hôpitaux ou aux services hospitaliers.

17.33(12) Sans restreindre la portée du paragraphe (11), nulle action pour révocation, soit expresse, implicite ou par interprétation, n'existe ou ne peut être engagée contre le Ministre ou la Couronne du chef de la province à l'égard de tout transfert ou de toute dévolution de droits, pouvoirs, fonctions ou responsabilités en vertu du présent article.

17.33(13) The Lieutenant-Governor in Council may make regulations

(a) respecting any matter necessary in connection with the appointment of officers by the Minister under this section and the transfer to and vesting in those officers of any rights, powers, duties or responsibilities; and

(b) respecting any matter necessary in connection with the termination under subsection (9) of the control and management by the Minister of the business and affairs of the bodies corporate listed in subsection (1), and the termination under subsection (9) of rights, powers, duties and responsibilities, including providing for the control and management of the business and affairs of those bodies corporate after such terminations and providing for the exercise of the rights and powers and the discharge of the duties and responsibilities of the boards and officers of those bodies corporate after such terminations.

17.33(13) Le lieutenant-gouverneur en conseil peut établir des règlements

a) concernant toute matière nécessaire en rapport avec la nomination des dirigeants par le Ministre en vertu du présent article et le transfert et la dévolution à ces dirigeants de tous droits, pouvoirs, fonctions ou responsabilités; et

b) concernant toute matière nécessaire en rapport avec la cessation en vertu du paragraphe (9) du contrôle et de la gestion par le Ministre de l'activité et des affaires internes des corps constitués énumérés au paragraphe (1), et la cessation en vertu du paragraphe (9) des droits, pouvoirs, fonctions et responsabilités, y compris prévoyant le contrôle et la gestion de l'activité et des affaires internes de ces corps constitués après ces cessations et prévoyant l'exercice des droits et pouvoirs et l'exécution des fonctions et responsabilités des conseils et des dirigeants de ces corps constitués après ces cessations.

APPENDIX B

BILL 64:

THE HOSPITAL ACT 1992



CHAPTER H-6.1

CHAPITRE H-6.1

Hospital Act

Loi hospitalière

Assented to May 20, 1992

Sanctionnée le 20 mai 1992

Chapter Outline

Sommaire

Definitions	1
admission — admission	
building service equipment — installation matérielle des bâtiments	
extra-mural services — services extra-muraux	
hospital corporation — corporaouon hospitalière	
hospital services — services hospitaliers	
Minister — Ministre	
patient — malade	
Establishment of Region 1 Hospital Corporation (South-East)/Corporaouon hospitalière de la Région 1 (sud-est)	2
Establishment of Region 1 Hospital Corporation (Beauséjour)/Corporaouon hospitalière de la Région 1 (Beauséjour)	3
Establishment of Region 2 Hospital Corporation/Corporaouon hospitalière de la Région 2	4
Establishment of Region 3 Hospital Corporation/Corporaouon hospitalière de la Région 3	5
Establishment of Region 4 Hospital Corporation/Corporaouon hospitalière de la Région 4	6
Establishment of Region 5 Hospital Corporation/Corporaouon hospitalière de la Région 5	7
Establishment of Region 6 Hospital Corporation/Corporaouon hospitalière de la Région 6	8
Establishment of Region 7 Hospital Corporation/Corporaouon hospitalière de la Région 7	9
Objects, purposes and capacity of a body corporate established by this Act or the regulations	10
Boards of trustees	11-13
By-laws	14
Chief executive officers	15
Advisory committees	15.1

Définitions	1
admission — admission	
corporation hospitalière — hospital corporation	
installation matérielle des bâtiments — building service equipment	
malade — patient	
Ministre — Ministre	
services extra-muraux — extra-mural services	
services hospitaliers — hospital services	
Établissement de la Corporaouon hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East)	2
Établissement de la Corporaouon hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour)	3
Établissement de la Corporaouon hospitalière de la Région 2/Region 2 Hospital Corporation	4
Établissement de la Corporaouon hospitalière de la Région 3/Region 3 Hospital Corporation	5
Établissement de la Corporaouon hospitalière de la Région 4/Region 4 Hospital Corporation	6
Établissement de la Corporaouon hospitalière de la Région 5/Region 5 Hospital Corporation	7
Établissement de la Corporaouon hospitalière de la Région 6/Region 6 Hospital Corporation	8
Établissement de la Corporaouon hospitalière de la Région 7/Region 7 Hospital Corporation	9
Objets, buts et capacité d'un corps constitué établi par la présente loi ou les règlements	10
Conseil de fiduciaires	11-13
Règlements administratifs	14
Directeurs généraux	15
Comités consultatifs	15.1

Chap. H-6.1

Loi hospitalière

Restrictions in relation to hospital facilities and real property used for hospital purposes	16
Restriction in relation to hospital services	17
Restriction in relation to funds and other assets	18
Trust and other funds	19
Admission	20
Death of indigent person	21
Training programs	22
Limitations, indemnification	23
Records, reports and returns	24
Financial matters	25
Insurance	26-28
Appointment of trustee	29
Hospital facilities no longer used as hospital facilities	30
Prohibition in relation to actions, applications and other proceedings	31
Act supersedes <i>Expropriation Act</i>	32
Offences and penalties	33
Administration of Act and regulations	34
Regulations	35
CENTRACARE SAINT JOHN INC.	36
CENTRE HOSPITALIER RESTIGOUCHE INC./ RESTIGOUCHE HOSPITAL CENTER INC.	37
Repeal	38
Commencement	39
Schedule A	

Restrictions relativement aux établissements hospitaliers et aux biens réels utilisés à des fins hospitalières	16
Restriction relativement aux services hospitaliers	17
Restriction relativement aux fonds et autres actifs	18
Fiducie et autres fonds	19
Admission	20
Décès d'une personne indigente	21
Programmes de formation	22
Prescriptions, dommages-intérêts	23
Dossiers, rapports et relevés	24
Matières financières	25
Assurance	26-28
Nomination de fiduciaires	29
Établissements hospitaliers non utilisés comme tels	30
Interdiction relativement aux actions, demandes et autres procédures	31
Priorité de la loi sur la <i>Loi sur l'expropriation</i>	32
Infractions et peines	33
Application de la loi et des règlements	34
Règlements	35
CENTRACARE SAINT JOHN INC.	36
CENTRE HOSPITALIER RESTIGOUCHE INC. / RESTIGOUCHE HOSPITAL CENTER INC.	37
Abrogation	38
Entrée en vigueur	39
Annexe A	

Her Majesty, by and with the advice and consent of the Legislative Assembly of New Brunswick, enacts as follows:

1 In this Act

"admission" includes the admission of a patient for out-patient services and the admission of a patient for extra-mural services;

"building service equipment" means equipment added to a building in order to heat, light, ventilate or otherwise render it serviceable, but which is not an integral part of the building itself and which may have a normal useful life that is different from that of the building to which it is attached;

Sa Majesté, sur l'avis et du consentement de l'Assemblée législative du Nouveau-Brunswick, décrète:

1 Dans la présente loi

«admission» s'entend également de l'admission d'un malade en consultation externe et de l'admission d'un malade recevant des services extra-muraux;

«corporation hospitalière» désigne

a) un corps constitué établi par la présente loi ou les règlements, et

*Hospital Act**Chap. H-6.1*

"extra-mural services" means acute, long term, rehabilitative or palliative care provided to a patient in the patient's place of residence;

"hospital corporation" means

(a) a body corporate established by this Act or the regulations, and

(b) a body corporate, other than one established by this Act or the regulations, that is designated by regulation as a hospital corporation for the purposes of this Act and the regulations;

"hospital services" includes extra-mural services;

"Minister" means the Minister of Health and Community Services and includes persons designated by the Minister under section 34 to act on the Minister's behalf;

"patient" means a person who receives hospital services from a hospital corporation.

1996, c.56, s.1.

2(1) There is established a body corporate to be known as Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est).

2(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establish-

b) un corps constitué, autre qu'un corps constitué établi par la présente loi ou les règlements, qui est désigné par règlement comme corporation hospitalière aux fins de la présente loi et des règlements;

«installation matérielle des bâtiments» désigne le matériel ajouté à un bâtiment en vue de le chauffer, l'éclairer, le ventiler ou le rendre autrement utilisable, mais qui ne fait pas partie intégrante du bâtiment même et qui peut avoir une durée d'utilisation normale qui diffère de celle du bâtiment auquel il est attaché;

«malade» désigne une personne qui reçoit des services hospitaliers d'une corporation hospitalière;

«Ministre» désigne le ministre de la Santé et des Services communautaires et s'entend également des personnes que le Ministre désigne en vertu de l'article 34 pour le représenter;

«services extra-muraux» désigne des soins de malade aigu, à long terme, de réadaptation ou palliatifs dispensés à un malade à son lieu de résidence;

«services hospitaliers» s'entend également des services extra-muraux.

1996, c.56, art.1.

2(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East).

2(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs

Chap. H-6.1

Loi hospitalière

ment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est):

- (a) The Moncton Hospital;
- (b) The Sackville Memorial Hospital;
- (c) THE ALBERT COUNTY HOSPITAL INC.;
- (d) Petitcodiac Health Centre; and
- (e) Health Services Centre, Rexton.

2(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est).

2(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of

ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East) et peuvent être exercés, acquittés ou exécutés par cette Corporation:

- a) The Moncton Hospital;
- b) The Sackville Memorial Hospital;
- c) THE ALBERT COUNTY HOSPITAL INC.;
- d) Petitcodiac Health Centre; et
- e) Health Services Centre de Rexton.

2(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East).

2(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit

*Hospital Act**Chap. H-6.1*

its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est).

de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East).

2(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

2(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est) or to the board of trustees or officers of Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est), as the case may be.

2(7) The medical staff of Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est), until altered by the board of trustees of Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est) in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

2(8) The members of the medical staff of Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est) have the same privileges at hospital facilities that they had imme-

2(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

2(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East) ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East), selon le cas.

2(7) Le personnel médical de la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East), jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East) conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

2(8) Les membres du personnel médical de la Corporation hospitalière de la Région 1 (sud-est)/Region 1 Hospital Corporation (South-East) ont les mêmes privilèges dans les établissements hospi-

*Chap. H-6.1**Loi hospitalière*

diately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 1 Hospital Corporation (South-East)/Corporation hospitalière de la Région 1 (sud-est) in accordance with this Act, the regulations and the by-laws of the Corporation.

3(1) There is established a body corporate to be known as Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour).

3(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour):

- (a) Doctor Georges L. Dumont Hospital;
- (b) L'Hôpital Stella Maris de Kent; and
- (c) Regional Medical Centre, Shediac.

taliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 1 (sud-est) Region 1 Hospital Corporation (South-East) conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

3(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour).

3(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour) et peuvent être exercés, acquittés ou exécutés par cette Corporation:

- a) Hôpital Docteur Georges L. Dumont;
- b) L'Hôpital Stella Maris de Kent; et
- c) Centre médical régional de Shediac.

*Hospital Act**Cnap. H-6.1*

3(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 1 Hospital Corporation (Beausejour)/Corporation hospitalière de la Région 1 (Beausejour).

3(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 1 Hospital Corporation (Beausejour)/Corporation hospitalière de la Région 1 (Beausejour).

3(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

3(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital fa-

3(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (Beausejour)/Region 1 Hospital Corporation (Beausejour).

3(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 1 (Beausejour)/Region 1 Hospital Corporation (Beausejour).

3(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

3(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au

*Chap. H-6.1**Loi hospitalière*

cilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour) or to the board of trustees or officers of Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour), as the case may be.

3(7) The medical staff of Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour), until altered by the board of trustees of Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour) in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

3(8) The members of the medical staff of Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour) have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 1 Hospital Corporation (Beauséjour)/Corporation hospitalière de la Région 1 (Beauséjour) in accordance with this Act, the regulations and the by-laws of the Corporation.

4(1) There is established a body corporate to be known as Region 2 Hospital Corporation/Corporation hospitalière de la Région 2.

4(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of in-

paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour) ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 1 (Beauséjour) 'Region 1 Hospital Corporation (Beauséjour), selon le cas.

3(7) Le personnel médical de la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour), jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour) conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

3(8) Les membres du personnel médical de la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour) ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 1 (Beauséjour)/Region 1 Hospital Corporation (Beauséjour) conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

4(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 2/Region 2 Hospital Corporation.

4(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi

corporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 2 Hospital Corporation/Corporation hospitalière de la Région 2:

- (a) Saint John Regional Hospital;
- (b) ST. JOSEPH'S HOSPITAL, SAINT JOHN, N.B.;
- (c) FUNDY HOSPITAL ASSOCIATION, LIMITED;
- (d) THE GRAND MANAN HOSPITAL, LIMITED;
- (e) The Charlotte County Hospital;
- (f) Sussex Health Centre;
- (g) Campobello Health Centre; and
- (h) CENTRACARE SAINT JOHN INC.

4(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or

que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

- a) Hôpital régional de Saint-Jean;
- b) ST. JOSEPH'S HOSPITAL, SAINT JOHN, N.B.;
- c) FUNDY HOSPITAL ASSOCIATION, LIMITED;
- d) THE GRAND MANAN HOSPITAL, LIMITED;
- e) The Charlotte County Hospital;
- f) Sussex Health Centre;
- g) Campobello Health Centre; et
- h) CENTRACARE SAINT JOHN INC.

4(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établisse-

*Chap. H-6.1**Loi hospitalière*

that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 2 Hospital Corporation/Corporation hospitalière de la Région 2.

4(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 2 Hospital Corporation/Corporation hospitalière de la Région 2.

4(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

4(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 2 Hospital Corporation/Corporation hospitalière de la Région 2 or to the board of trustees or officers of Region 2 Hospital Corporation/Corporation hospitalière de la Région 2, as the case may be.

ments hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation.

4(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation.

4(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

4(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation, selon le cas.

*Hospital Act**Char. H-6.1*

4(7) The medical staff of Region 2 Hospital Corporation/Corporation hospitalière de la Région 2, until altered by the board of trustees of Region 2 Hospital Corporation/Corporation hospitalière de la Région 2 in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

4(8) The members of the medical staff of Region 2 Hospital Corporation/Corporation hospitalière de la Région 2 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 2 Hospital Corporation/Corporation hospitalière de la Région 2 in accordance with this Act, the regulations and the by-laws of the corporation.

5(1) There is established a body corporate to be known as Region 3 Hospital Corporation Corporation hospitalière de la Région 3.

5(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service

4(7) Le personnel médical de la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation, jusqu'à ce qu'il soit change par le conseil de fiduciaires de la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

4(8) Les membres du personnel médical de la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet, soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 2/Region 2 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

5(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 3 Region 3 Hospital Corporation.

5(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre,

Chap. H-6.1

Loi hospitalière

equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 3 Hospital Corporation/ Corporation hospitalière de la Région 3:

- (a) Dr. Everett Chalmers Hospital;
- (b) Oromocto Public Hospital;
- (c) Queens North Hospital;
- (d) Harvey Community Hospital;
- (e) MacLean Memorial Hospital;
- (f) Health Services Centre, Village of Stanley;
- (g) Health Services Centre, Village of Fred-
erickton Junction;
- (h) The Carleton Memorial Hospital;
- (i) L'HOTEL-DIEU SAINT-JOSEPH DE
PERTH-ANDOVER INC;
- (j) The Tobique Valley Hospital;
- (k) FOREST HILL REHABILITATION
CENTRE INC.;
- (l) Northern Carleton Hospital; and
- (m) Upper Miramichi Health Centre.

5(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are,

et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

- a) Hôpital Dr Everett Chalmers;
- b) Oromocto Public Hospital;
- c) Queens North Hospital;
- d) Harvey Community Hospital;
- e) MacLean Memorial Hospital;
- f) Centre de soins médicaux, Village de Stan-
ley;
- g) Centre de soins médicaux, Village de Fred-
erickton Junction;
- h) The Carleton Memorial Hospital;
- i) L'HOTEL-DIEU SAINT-JOSEPH DE
PERTH-ANDOVER INC;
- j) The Tobique Valley Hospital;
- k) FOREST HILL REHABILITATION
CENTRE INC.;
- l) Northern Carleton Hospital; et
- m) Upper Miramichi Health Centre.

5(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services

*Hospital Act**Chap. H-6.1*

without further action, transferred to and vested in Region 3 Hospital Corporation/Corporation hospitalière de la Région 3.

5(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 3 Hospital Corporation/Corporation hospitalière de la Région 3.

5(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

5(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 3 Hospital Corporation/Corporation hospitalière de la Région 3 or to the board of trustees or officers of Region 3 Hospital Corporation/Corporation hospitalière de la Région 3, as the case may be.

ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation.

5(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation.

5(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

5(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation, selon le cas.

*Chap. H-6.1**Loi hospitalière*

5(7) The medical staff of Region 3 Hospital Corporation/Corporation hospitalière de la Région 3, until altered by the board of trustees of Region 3 Hospital Corporation/Corporation hospitalière de la Région 3 in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

5(8) The members of the medical staff of Region 3 Hospital Corporation/Corporation hospitalière de la Région 3 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 3 Hospital Corporation/Corporation hospitalière de la Région 3 in accordance with this Act, the regulations and the by-laws of the Corporation.

6(1) There is established a body corporate to be known as Region 4 Hospital Corporation/Corporation hospitalière de la Région 4.

6(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service

5(7) Le personnel médical de la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation, jusqu'à ce qu'il soit change par le conseil des fiduciaires de la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

5(8) Les membres du personnel médical de la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 3/Region 3 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

6(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 4/Region 4 Hospital Corporation.

6(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre,

*Hospital Act**Chap. H-6.1*

equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 4 Hospital Corporation/Corporation hospitalière de la Région 4:

(a) Edmundston Regional Hospital;

(b) GRAND FALLS GENERAL HOSPITAL INC. - L'HOPITAL GENERAL DE GRAND SAULT INC.; and

(c) L'HOTEL-DIEU SAINT-JOSEPH DE SAINT-QUENTIN INC.

6(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 4 Hospital Corporation/Corporation hospitalière de la Région 4.

6(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 4 Hospital Corporation/Corporation hospitalière de la Région 4.

6(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act

et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

a) Hôpital régional d'Edmundston;

b) GRAND FALLS GENERAL HOSPITAL INC. - L'HOPITAL GENERAL DE GRAND SAULT INC.; et

c) L'HOTEL-DIEU SAINT-JOSEPH DE SAINT-QUENTIN INC.

6(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation.

6(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation.

6(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements éta-

Chap. H-6.1

Loi hospitalière

of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

6(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 4 Hospital Corporation/Corporation hospitalière de la Région 4 or to the board of trustees or officers of Region 4 Hospital Corporation/Corporation hospitalière de la Région 4, as the case may be.

6(7) The medical staff of Region 4 Hospital Corporation/Corporation hospitalière de la Région 4, until altered by the board of trustees of Region 4 Hospital Corporation/Corporation hospitalière de la Région 4 in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

6(8) The members of the medical staff of Region 4 Hospital Corporation/Corporation hospitalière de la Région 4 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 4 Hospital Corpora-

blis en vertu de toute autre loi de la Legislature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

6(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Legislature, dans les règlements établis en vertu de toute autre loi de la Legislature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation, selon le cas.

6(7) Le personnel médical de la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation, jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

6(8) Les membres du personnel médical de la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par

tion/Corporation hospitalière de la Région 4 in accordance with this Act, the regulations and the by-laws of the Corporation.

le conseil de fiduciaires de la Corporation hospitalière de la Région 4/Region 4 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

7(1) There is established a body corporate to be known as Region 5 Hospital Corporation/Corporation hospitalière de la Région 5.

7(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 5/Region 5 Hospital Corporation.

7(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 5 Hospital Corporation/Corporation hospitalière de la Région 5:

7(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

(a) Campbellton Regional Hospital;

a) Hôpital régional de Campbellton;

(b) Hopital St. Joseph de Dalhousie;

b) Hopital St. Joseph de Dalhousie;

(c) CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC.; and

c) CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC.; et

(d) East Restigouche Community Health Care Centre.

d) Centre communautaire de santé de Restigouche-est.

*Chap. H-6.1**Loi hospitalière*

7(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 5 Hospital Corporation/Corporation hospitalière de la Région 5.

7(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 5 Hospital Corporation/Corporation hospitalière de la Région 5.

7(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

7(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital fa-

7(3) Tous les biens et tous les droits dans les biens à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation.

7(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation.

7(5) Nonobstant toute disposition dans toute autre loi de la Legislature, dans les règlements établis en vertu de toute autre loi de la Legislature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

7(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Legislature, dans les règlements établis en vertu de toute autre loi de la Legislature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux

cility, be read as a reference to Region 5 Hospital Corporation/Corporation hospitalière de la Région 5 or to the board of trustees or officers of Region 5 Hospital Corporation/Corporation hospitalière de la Région 5, as the case may be.

7(7) The medical staff of Region 5 Hospital Corporation/Corporation hospitalière de la Région 5, until altered by the board of trustees of Region 5 Hospital Corporation/Corporation hospitalière de la Région 5 in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

7(8) The members of the medical staff of Region 5 Hospital Corporation/Corporation hospitalière de la Région 5 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 5 Hospital Corporation/Corporation hospitalière de la Région 5 in accordance with this Act, the regulations and the by-laws of the Corporation.

8(1) There is established a body corporate to be known as Region 6 Hospital Corporation/Corporation hospitalière de la Région 6.

8(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or

services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entend de renvois à la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation, selon le cas.

7(7) Le personnel médical de la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation, jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

7(8) Les membres du personnel médical de la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 5/Region 5 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

8(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 6/Region 6 Hospital Corporation.

8(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts cons-

Chap. H-6.1

Loi hospitalière

hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or discharged by, Region 6 Hospital Corporation/Corporation hospitalière de la Région 6:

- (a) Chaleur Regional Hospital;
- (b) L'HOPITAL DE L'ENFANT-JESUS INC;
- (c) Hôpital de Tracadie;
- (d) Hôpital de Lamèque;
- (e) Centre de Santé - Paquetville; and
- (f) L'HOTEL-DIEU SAINT-JOSEPH DE TRACADIE INC.

8(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 6 Hospital Corporation/Corporation hospitalière de la Région 6.

titutifs, par lettres parentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le Ministre, à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

- a) Hôpital régional Chaleur;
- b) L'HOPITAL DE L'ENFANT-JESUS INC;
- c) Hôpital de Tracadie;
- d) Hôpital de Lamèque;
- e) Centre de Santé - Paquetville; et
- f) L'HOTEL-DIEU SAINT-JOSEPH DE TRACADIE INC.

8(3) Tous les biens et tous les droits dans les biens à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation.

8(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 6 Hospital Corporation/Corporation hospitalière de la Région 6.

8(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers shall not establish, operate or maintain a hospital facility or provide hospital services.

8(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 6 Hospital Corporation/Corporation hospitalière de la Région 6 or to the board of trustees or officers of Region 6 Hospital Corporation/Corporation hospitalière de la Région 6, as the case may be.

8(7) The medical staff of Region 6 Hospital Corporation/Corporation hospitalière de la Région 6, until altered by the board of trustees of Region 6 Hospital Corporation/Corporation hospitalière de la Région 6 in accordance with this Act and the regulations, and the by-laws of the Corporation,

8(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation.

8(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

8(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation, selon le cas.

8(7) Le personnel médical de la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation, jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation conformément à la présente loi et aux règle-

*Chap. H-6.1**Loi hospitalière*

consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

8(8) The members of the medical staff of Region 6 Hospital Corporation/Corporation hospitalière de la Région 6 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 6 Hospital Corporation/Corporation hospitalière de la Région 6 in accordance with this Act, the regulations and the by-laws of the Corporation.

9(1) There is established a body corporate to be known as Region 7 Hospital Corporation/Corporation hospitalière de la Région 7.

9(2) All rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether established or assigned by an Act of the Legislature, by regulations under an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, of the following bodies corporate, their governing bodies and their officers that relate to hospital facilities or hospital services, or that are associated with the establishment, operation or maintenance of a hospital facility, including those transferred to and vested in the Minister effective April 1, 1992, those transferred to and vested in officers appointed by the Minister, and those acquired after March 31, 1992 by the Minister or by officers appointed by the Minister, but excluding those that relate to land, buildings and building service equipment, are, without further action, transferred to and vested in, and may be exercised or

ments, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

8(8) Les membres du personnel médical de la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 6/Region 6 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

9(1) Est établi un corps constitué appelé Corporation hospitalière de la Région 7/Region 7 Hospital Corporation.

9(2) Tous les droits, tous les pouvoirs, tous les privilèges, toutes les concessions, tous les titres, toutes les dettes, toutes les obligations, tous les engagements, toutes les fonctions et toutes les responsabilités des corps constitués suivants ainsi que de leurs conseils d'administration et de leurs dirigeants, qu'ils soient établis ou assignés par une loi de la Législature, par règlements établis en vertu d'une loi de la Législature, par statuts constitutifs, par lettres patentes, par règlements administratifs ou par tout autre document ou instrument, et qui se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, y compris ceux qui sont transférés et dévolus au Ministre à partir du 1^{er} avril 1992, ceux qui sont transférés et dévolus aux dirigeants nommés par le Ministre, et ceux qui sont acquis après le 31 mars 1992 par le Ministre ou par les dirigeants nommés par le

*Hospital Act**Chac. H-6.1*

discharged by, Region 7 Hospital Corporation/
Corporation hospitalière de la Région 7:

(a) Religious Hospitallers of St. Joseph of
Chatham, N.B.;

(b) The Miramichi Hospital; and

(c) Rogersville Health Centre.

9(3) All property and all interests in property, except land, buildings and building service equipment, of the bodies corporate listed in subsection (2), of their governing bodies and their officers, that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility are, without further action, transferred to and vested in Region 7 Hospital Corporation/Corporation hospitalière de la Région 7.

9(4) Without restricting the generality of subsection (3), all funds standing to the credit of a body corporate listed in subsection (2) or to the credit of its governing body or its officers that were provided by the Province for purposes of funding operations or capital expenditures in relation to hospital services or hospital facilities, including interest that has accrued on the funds, are, without further action, transferred to and vested in Region 7 Hospital Corporation/Corporation hospitalière de la Région 7.

9(5) Despite any provision in any other Act of the Legislature, in regulations under any other Act of the Legislature, in articles of incorporation, in letters patent, in by-laws or in any other document or instrument, the bodies corporate listed in subsection (2), their governing bodies and their officers,

à l'exception de ceux qui se rapportent aux terrains, aux bâtiments et à l'installation matérielle des bâtiments, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation et peuvent être exercés, acquittés ou exécutés par cette Corporation:

a) Religious Hospitallers of St. Joseph of
Chatham, N.B.;

b) The Miramichi Hospital; et

c) Centre de santé de Rogersville.

9(3) Tous les biens et tous les droits dans les biens, à l'exception des terrains, des bâtiments et de l'installation matérielle des bâtiments, des corps constitués énumérés au paragraphe (2) ainsi que de leurs conseils d'administration et de leurs dirigeants, qui sont utilisés pour des établissements hospitaliers ou des services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation.

9(4) Sans restreindre la portée du paragraphe (3), tous les fonds se trouvant au crédit d'un corps constitué mentionné au paragraphe (2) ou au crédit de son conseil d'administration ou de ses dirigeants, qui furent fournis par la province pour subventionner les activités ou les dépenses en capital relativement aux services hospitaliers ou aux établissements hospitaliers, y compris les intérêts courus sur les fonds, sont, sans autres formalités, transférés et dévolus à la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation.

9(5) Nonobstant toute disposition dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature, dans tous statuts constitutifs, dans toutes lettres patentes, dans tous règlements administratifs ou dans tout autre document ou instrument, les corps

*Chap. H-6.1**Loi hospitalière*

ers shall not establish, operate or maintain a hospital facility or provide hospital services.

9(6) Unless the context requires otherwise, a reference in any other Act of the Legislature, in regulations under any other Act of the Legislature or in any other document or instrument to a body corporate listed in subsection (2), or to the governing body or the officers of a body corporate listed in subsection (2), shall, as it relates to hospital facilities or hospital services, or to the establishment, operation or maintenance of a hospital facility, be read as a reference to Region 7 Hospital Corporation/Corporation hospitalière de la Région 7 or to the board of trustees or officers of Region 7 Hospital Corporation/Corporation hospitalière de la Région 7, as the case may be.

9(7) The medical staff of Region 7 Hospital Corporation/Corporation hospitalière de la Région 7, until altered by the board of trustees of Region 7 Hospital Corporation/Corporation hospitalière de la Région 7 in accordance with this Act and the regulations, and the by-laws of the Corporation, consists of the persons who were members of the medical staff of the bodies corporate listed in subsection (2) immediately before the commencement of this subsection.

9(8) The members of the medical staff of Region 7 Hospital Corporation/Corporation hospitalière de la Région 7 have the same privileges at hospital facilities that they had immediately before the commencement of this subsection until those privileges expire or are altered or withdrawn by the board of trustees of Region 7 Hospital Corporation/Corporation hospitalière de la Région 7 in accordance with this Act, the regulations and the by-laws of the Corporation.

constitués énumérés au paragraphe (2) ainsi que leurs conseils d'administration et leurs dirigeants ne peuvent établir, exploiter ou maintenir un établissement hospitalier ou dispenser des services hospitaliers.

9(6) Sauf indication contraire du contexte, les renvois dans toute autre loi de la Législature, dans les règlements établis en vertu de toute autre loi de la Législature ou dans tout autre document ou instrument, à un corps constitué mentionné au paragraphe (2), ou au conseil d'administration ou aux dirigeants d'un corps constitué mentionné au paragraphe (2), doivent, en autant qu'ils se rapportent aux établissements hospitaliers ou aux services hospitaliers, ou à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier, s'entendre de renvois à la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation ou au conseil de fiduciaires ou aux dirigeants de la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation, selon le cas.

9(7) Le personnel médical de la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation, jusqu'à ce qu'il soit changé par le conseil de fiduciaires de la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation conformément à la présente loi et aux règlements, et aux règlements administratifs de cette Corporation, se compose des personnes qui étaient membres du personnel médical des corps constitués énumérés au paragraphe (2) immédiatement avant l'entrée en vigueur du présent paragraphe.

9(8) Les membres du personnel médical de la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation ont les mêmes privilèges dans les établissements hospitaliers qu'ils avaient immédiatement avant l'entrée en vigueur du présent paragraphe jusqu'à ce que ces privilèges cessent d'avoir effet ou soient modifiés ou retirés par le conseil de fiduciaires de la Corporation hospitalière de la Région 7/Region 7 Hospital Corporation conformément à la présente loi, aux règlements et aux règlements administratifs de cette Corporation.

*Hospital Act**Chap. H-6.1*

10(1) The objects and purposes of a body corporate established by this Act or the regulations are, subject to the provisions of this Act and the regulations,

(a) to establish, operate and maintain hospital facilities, not for pecuniary gain but exclusively for charitable purposes,

(b) to deliver hospital services in the hospital facilities established, operated and maintained, or operated and maintained, by the body corporate,

(b.1) to deliver those hospital services that are extra-mural services within the geographic area or areas specified by the Minister,

(c) to engage in programs to train persons in the medical and allied professions, and

(d) to do such additional things as are approved by the Minister or prescribed by regulation.

10(2) A body corporate established by this Act or the regulations has the capacity and, subject to this Act and the regulations, the rights, powers and privileges of a natural person, for the purpose of carrying out its objects and purposes.

1996, c.56, s.2.

11(1) The business and affairs of a hospital corporation shall be controlled and managed by a board of trustees appointed or selected in accordance with the regulations.

11(2) A majority of the voting members of the board of trustees of a hospital corporation constitutes a quorum, and an act of a majority of the voting members present and voting shall be deemed to be an act of the board of trustees.

10(1) Les objets et buts d'un corps constitué établi par la présente loi ou les règlements sont, sous réserve des dispositions de la présente loi et des règlements,

a) d'établir, d'exploiter et de maintenir des établissements hospitaliers, non pas en vue d'un gain pécuniaire mais uniquement pour des fins de charité,

b) de dispenser des services hospitaliers dans les établissements hospitaliers établis, exploités et maintenus par le corps constitué, ou exploités et maintenus par le corps constitué,

b.1) de dispenser des services hospitaliers qui sont des services extra-muraux dans le ou les secteurs géographiques stipulés par le Ministre,

c) de réaliser des programmes de formation de personnes aux professions médicales et paramédicales, et

d) d'accomplir les choses additionnelles qui sont agréées par le Ministre ou prescrites par règlement.

10(2) Un corps constitué établi par la présente loi ou des règlements a la capacité et, sous réserve de la présente loi et des règlements, les droits, pouvoirs et privilèges d'une personne physique, aux fins de l'exécution de ses objets et buts.

1996, c.56, art.2.

11(1) L'activité et les affaires internes d'une corporation hospitalière doivent être contrôlées et gérées par un conseil de fiduciaires nommé ou choisi conformément aux règlements.

11(2) Une majorité des membres avec droit de vote du conseil de fiduciaires d'une corporation hospitalière constitue le quorum, et une mesure venant d'une majorité des membres présents avec droit de vote et votant est réputée être une mesure du conseil de fiduciaires.

*Chap. H-6.1**Loi hospitalière*

11(3) A member of the board of trustees of a hospital corporation shall not vote by proxy at a meeting of the board of trustees.

11(4) A member of the board of trustees of a hospital corporation may participate in a meeting of the board of trustees or of a committee of the board of trustees by means of telephone or other communication facilities that permit all persons participating in the meeting to hear each other if

(a) the by-laws of the hospital corporation so provide, or

(b) subject to the by-laws, all members of the board of trustees consent.

11(5) A member of a board of trustees participating in a meeting in accordance with subsection (4) shall be deemed to be present at the meeting.

11(6) If, with respect to the board of trustees of a hospital corporation, there is a conflict between this Act and the regulations and any other Act of the Legislature, any regulation under any other Act of the Legislature, any articles of incorporation, letters patent, by-laws or other document or instrument, this Act and the regulations prevail.

12(1) Despite subsection 11(1), the first boards of trustees of the hospital corporations established by subsections 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1) and 9(1) shall be as follows:

(a) not fewer than twelve and not more than sixteen voting members appointed by the Minister,

(b) the chief executive officer of the hospital corporation appointed under section 15, who shall be a non-voting member, and

11(3) Un membre du conseil de fiduciaires d'une corporation hospitalière ne peut voter par procuration lors d'une réunion du conseil de fiduciaires.

11(4) Un membre du conseil de fiduciaires d'une corporation hospitalière peut participer à une réunion du conseil de fiduciaires ou d'un de ses comités par l'utilisation des moyens techniques, notamment le téléphone, permettant à tous les participants de s'entendre et de communiquer verbalement entre eux, si

a) les règlements administratifs le prévoient, ou

b) sous réserve des règlements administratifs, tous les membres du conseil de fiduciaires y consentent.

11(5) Un membre du conseil de fiduciaires qui participe à une réunion conformément au paragraphe (4) est réputé être présent à cette réunion.

11(6) En cas de conflit relativement au conseil de fiduciaires d'une corporation hospitalière, entre la présente loi et les règlements et toute autre loi de la Législature, tout règlement établi en vertu d'une autre loi de la Législature, tous statuts corporatifs, toutes lettres patentes, tous règlements administratifs ou tout autre document ou instrument, la présente loi et ses règlements l'emportent.

12(1) Nonobstant le paragraphe 11(1), les premiers conseils de fiduciaires des corporations hospitalières établis par les paragraphes 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1) et 9(1) se composent comme suit:

a) d'au moins douze et d'au plus seize membres avec droit de vote nommés par le Ministre,

b) du directeur général de la corporation hospitalière nommé en vertu de l'article 15, qui doit être un membre sans droit de vote, et

*Hospital Act**Chap. H-6.1*

(c) the president of the medical staff of the hospital corporation, when one is appointed, who shall be a non-voting member.

c) du président du personnel médical de la corporation hospitalière, lorsqu'il y en a un de nommé, qui doit être un membre sans droit de vote.

12(2) For the purposes of paragraph (1)(a), the Minister shall determine the number of voting members, which number may be different for different hospital corporations.

12(2) Aux fins de l'alinéa (1)a), le Ministre fixe le nombre de membres avec droit de vote, lequel nombre peut être différent pour les différentes corporations hospitalières.

- 12(3) A determination by the Minister under subsection (2) is not a regulation within the meaning of the *Regulations Act*.
- 12(4) If the president of the medical staff is an employee of the hospital corporation, the medical staff shall select a member of the medical staff who is not an employee of the hospital corporation to be a non-voting member of the board of trustees.
- 12(5) From among the members of the first boards of trustees appointed under this section the Minister shall appoint chairpersons of the first boards of trustees.
- 12(6) Members and chairpersons of the first boards of trustees appointed under this section serve at the pleasure of the Minister.
- 12(7) The appointments made under this section terminate at the end of June 30, 1994 or at the end of such earlier date as may be fixed by the Minister.
- 12(8) After appointments are made under this section the first boards of trustees shall meet and may
- (a) make hospital corporation by-laws,
 - (b) elect or appoint officers,
 - (c) make banking arrangements, and
 - (d) transact any other business.
- 12(9) If a vacancy occurs among members of the first boards of trustees appointed under this section the Minister may appoint a person to fill the vacancy.
- 13 In controlling and managing the business and affairs of a hospital corporation, a board of trustees

- 12(3) Une fixation par le Ministre en vertu du paragraphe (2) ne constitue pas un règlement au sens de la *Loi sur les règlements*.
- 12(4) Si le président du personnel médical est un employé de la corporation hospitalière, le personnel médical doit choisir un membre du personnel médical qui n'est pas un employé de la corporation hospitalière comme membre sans droit de vote du conseil de fiduciaires.
- 12(5) Parmi les membres des premiers conseils de fiduciaires nommés en vertu du présent article, le Ministre nomme les présidents des premiers conseils de fiduciaires.
- 12(6) Les membres et les présidents des premiers conseils de fiduciaires nommés en vertu du présent article sont en fonction durant bon plaisir du Ministre.
- 12(7) Les nominations faites en vertu du présent article cessent d'avoir effet à l'expiration du 30 juin 1994 ou à l'expiration d'une date plus rapprochée qui peut être fixée par le Ministre.
- 12(8) Lorsque les nominations sont faites en vertu du présent article, les premiers conseils de fiduciaires doivent se réunir et ils peuvent
- a) établir les règlements administratifs de la corporation hospitalière,
 - b) choisir ou nommer des dirigeants,
 - c) établir des dispositions bancaires, et
 - d) conclure toutes autres affaires.
- 12(9) Si une vacance survient parmi les membres des premiers conseils de fiduciaires nommés en vertu du présent article, le Ministre peut nommer une personne pour remplir la vacance.
- 13 Dans sa fonction de contrôle et de gestion de l'activité et des affaires internes d'une corporation hospitalière, un conseil de fiduciaires

Chap. H-6.1

Loi hospitalière

(a) shall ensure that the hospital services delivered by the hospital corporation are delivered within the parameters established and the directions issued by the Minister.

(b) shall ensure that the hospital services delivered by the hospital corporation are delivered in accordance with established Provincial quality and efficiency standards, and

(c) shall ensure that land, buildings and building service equipment entrusted to the hospital corporation by the Crown in right of the Province are used for the purposes for which they were received and are well maintained so as to be available as required to support the delivery of hospital services.

14(1) A board of trustees of a hospital corporation may make, amend and repeal hospital corporation by-laws for the control and management of the business and affairs of the hospital corporation.

14(2) Hospital corporation by-laws shall be composed of administrative by-laws and medical staff by-laws.

14(3) Hospital corporation by-laws have no force or effect until they are approved by the Minister.

15(1) Despite anything in the regulations, the Minister shall appoint the first chief executive officers for the hospital corporations established by subsections 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1) and 9(1).

15(2) Chief executive officers appointed under this section serve at the pleasure of the Minister.

15(3) The appointments made under this section terminate at the end of June 30, 1994 or at the end of such earlier date as may be fixed by the Minister.

a) doit s'assurer que les services hospitaliers dispensés par la corporation hospitalière soient dispensés suivant les paramètres établis par le Ministre et les directives délivrées par celui-ci.

b) doit s'assurer que les services hospitaliers dispensés par la corporation hospitalière soient dispensés conformément aux normes provinciales reconnues de qualité et de compétence, et

c) doit s'assurer que les terrains, les bâtiments et l'installation matérielle des bâtiments confiés à la corporation hospitalière par la Couronne du chef de la province soient utilisés aux fins pour lesquelles ils furent reçus et qu'ils soient bien entretenus de sorte qu'ils soient disponibles lorsque requis pour aider à la dispensation des services hospitaliers.

14(1) Un conseil de fiduciaires d'une corporation hospitalière peut établir, modifier et abroger les règlements administratifs de la corporation hospitalière pour le contrôle et la gestion de l'activité et des affaires internes de la corporation hospitalière.

14(2) Les règlements administratifs de la corporation hospitalière comprennent les règlements administratifs concernant la gestion et les règlements administratifs concernant le personnel médical.

14(3) Les règlements administratifs d'une corporation hospitalière n'entrent en vigueur que lorsqu'ils sont approuvés par le Ministre.

15(1) Nonobstant quoi que ce soit dans les règlements, le Ministre doit nommer les premiers directeurs généraux pour les corporations hospitalières établies par les paragraphes 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1) et 9(1).

15(2) Les directeurs généraux nommés en vertu du présent article demeurent en fonction durant bon plaisir du Ministre.

15(3) Les nominations faites en vertu du présent article cessent d'avoir effet à l'expiration du 30 juin 1994 ou à l'expiration d'une date plus rapprochée qui peut être fixée par le Ministre.

15.1(1) There shall be an advisory committee for each hospital facility that is owned in whole or in part by a religious order and that is operated by a hospital corporation.

15.1(2) The members of an advisory committee referred to in subsection (1) shall be appointed by and report to the religious order that owns the hospital facility in whole or in part.

15.1(3) The purpose of an advisory committee is to ensure the preservation of the religious philosophy, values and mission associated with the hospital facility.

15.1(4) An advisory committee may

(a) prescribe for the hospital facility a statement respecting the philosophy, values and mission to be associated with the delivery of hospital services at the hospital facility,

(b) determine the mission programs and services essential to fulfil the mission set out in the statement prescribed under paragraph (a),

(c) monitor compliance with the statement prescribed under paragraph (a) and the mission programs and services determined under paragraph (b), and

(d) do such additional things as are prescribed by regulation.

15.1(5) The philosophy, values and mission set out in a statement prescribed under subsection (4) and the mission programs and services determined under subsection (4) shall not conflict with the parameters established and the directions issued by the Minister in relation to the planning, organization, management and delivery of hospital services by hospital corporations.

15.1(1) Est établi un comité consultatif pour chaque établissement hospitalier appartenant en tout ou en partie à une communauté religieuse et qui est exploité par une corporation hospitalière.

15.1(2) Les membres d'un comité consultatif prévu au paragraphe (1) sont nommés par la communauté religieuse à qui appartient en tout ou en partie l'établissement hospitalier et relèvent de cette communauté religieuse.

15.1(3) Le but d'un comité consultatif est d'assurer la préservation de la philosophie, des valeurs et des objectifs généraux à caractère religieux associés à l'établissement hospitalier.

15.1(4) Un comité consultatif peut

a) prescrire pour l'établissement hospitalier une déclaration concernant la philosophie, les valeurs et les objectifs généraux qui doivent être associés à la dispensation des services hospitaliers à l'établissement hospitalier,

b) déterminer les programmes et les services relatifs aux objectifs généraux qui sont essentiels pour réaliser les objectifs généraux établis dans la déclaration prescrite en vertu de l'alinéa a),

c) surveiller l'observance de la déclaration prescrite en vertu de l'alinéa a) et des programmes et services relatifs aux objectifs généraux déterminés en vertu de l'alinéa b), et

d) accomplir les choses additionnelles qui sont prescrites par règlement.

15.1(5) La philosophie, les valeurs et les objectifs généraux indiqués dans la déclaration prescrite en vertu du paragraphe (4) et les programmes et les services relatifs aux objectifs généraux déterminés en vertu du paragraphe (4) ne peuvent entrer en conflit avec les paramètres établis par le Ministre et les directives délivrées par celui-ci relativement à la planification, à l'organisation, à la gestion et la dispensation des services hospitaliers par les corporations hospitalières.

15.1(6) The Minister shall not, in relation to a hospital facility for which there is an advisory committee, approve the delivery of hospital services that conflict with the philosophy, values and mission set out in a statement prescribed under subsection (4).

1993, c.63, s.1.

16(1) No person other than a hospital corporation shall establish, operate or maintain a hospital facility in the Province.

16(2) A hospital corporation shall not establish, operate or maintain a hospital facility without the prior written approval of the Minister.

16(3) A hospital corporation shall not use a building or other premises or place as a hospital facility without the prior written approval of the Minister.

16(4) A hospital corporation shall not add to or otherwise alter a hospital facility without the prior written approval of the Minister unless the proposed addition or alteration will not result in additional continuing operating costs and the capital cost of the addition or alteration is less than twenty-five thousand dollars.

16(5) A hospital corporation shall not close, sell, lease, mortgage or otherwise dispose of or encumber any land, building, facility, premises or place or part of any land, building, facility, premises or place that is used for hospital purposes without the prior written approval of the Minister.

17 A hospital corporation shall not deliver a hospital service without the prior written approval of the Minister.

15.1(6) Le Ministre ne peut, relativement à un établissement hospitalier pour lequel il existe un comité consultatif, autoriser la dispensation des services hospitaliers qui entrent en conflit avec la philosophie, les valeurs et les objectifs généraux indiqués dans une déclaration prescrite en vertu du paragraphe (4).

1993, c.63, art.1.

16(1) Nulle personne autre qu'une corporation hospitalière ne peut établir, exploiter ou maintenir un établissement hospitalier dans la province.

16(2) Une corporation hospitalière ne peut établir, exploiter ou maintenir un établissement hospitalier sans l'autorisation préalable écrite du Ministre.

16(3) Une corporation hospitalière ne peut utiliser un bâtiment ou d'autres lieux ou endroits comme établissement hospitalier sans l'autorisation préalable écrite du Ministre.

16(4) Une corporation hospitalière ne peut agrandir ou autrement modifier un établissement hospitalier sans l'autorisation préalable écrite du Ministre sauf si l'agrandissement ou la modification projeté ne peut avoir comme conséquence des frais d'exploitation additionnels continus et si le coût des immobilisations de l'agrandissement ou de la modification est inférieur à vingt-cinq mille dollars.

16(5) Une corporation hospitalière ne peut, sans avoir obtenu au préalable l'autorisation écrite du Ministre, fermer, vendre, louer, hypothéquer ou disposer de quelque autre façon que ce soit ou grever d'une charge un terrain, un bâtiment, un établissement, des lieux ou un endroit ou partie d'un terrain, d'un bâtiment, d'un établissement, de lieux ou d'un endroit qui sont utilisés à des fins hospitalières.

17 Une corporation hospitalière ne peut dispenser un service hospitalier sans l'autorisation préalable écrite du Ministre.

18 A hospital corporation shall not use any funds or other property received from any source for a purpose that would result in additional continuing operating costs to the public without the prior written approval of the Minister.

18 Une corporation hospitalière ne peut utiliser sans l'approbation préalable écrite du Ministre, des fonds ou d'autres biens reçus de n'importe quelle source à des fins qui entraîneraient des frais d'exploitation additionnels continus pour le public.

19(1) A hospital corporation shall not use the capital of trust or other funds over which the hospital corporation exercises powers and discharges responsibilities of a fiduciary or other nature without the prior written approval of the Minister.

19(1) Une corporation hospitalière ne peut utiliser le capital d'une fiducie ou d'autres fonds sur lesquels la corporation hospitalière exerce des pouvoirs et exécute des responsabilités d'une nature fiduciaire ou d'une autre nature sans l'autorisation préalable écrite du Ministre.

19(2) Despite subsection (1), the capital of trust or other funds over which a hospital corporation exercises powers and discharges responsibilities of a fiduciary or other nature may be used without the prior written approval of the Minister if a specific directive in the instrument creating the fund authorizes the use of the capital.

19(2) Nonobstant le paragraphe (1), le capital d'une fiducie ou d'autres fonds sur lesquels une corporation hospitalière exerce des pouvoirs et exécute des responsabilités d'une nature fiduciaire ou d'une autre nature peut être utilisé sans l'approbation préalable écrite du Ministre si une directive spécifique dans l'instrument créant le fonds autorise l'utilisation du capital.

19(3) The transfer and vesting by this Act or the regulations of powers and responsibilities of a fiduciary or other nature over trust or other funds does not alter the purposes for which the trust or other funds were established, and the funds shall be used for the hospital facility for which they were intended.

19(3) Le transfert et la dévolution par la présente loi ou les règlements des pouvoirs et responsabilités d'une nature fiduciaire ou d'une autre nature sur une fiducie ou d'autres fonds ne change pas les fins pour lesquelles la fiducie ou les autres fonds furent établis, et les fonds doivent être utilisés pour l'établissement hospitalier pour lequel ils étaient destinés.

19(4) If a hospital corporation that exercises powers and discharges responsibilities of a fiduciary or other nature over trust or other funds ceases to exist, the funds are subject to the direction of the Minister who shall ensure that the funds are used for a purpose similar to the purpose for which they were intended.

19(4) Si une corporation hospitalière qui exerce des pouvoirs et exécute des responsabilités d'une nature fiduciaire ou d'une autre nature sur une fiducie ou d'autres fonds cesse d'exister, les fonds sont placés sous le contrôle du Ministre qui doit s'assurer que les fonds soient utilisés pour une fin similaire à celle à laquelle ils furent destinés.

20(1) Subject to subsections (2) and (3), a hospital corporation shall not refuse to admit as a patient a person who, from sickness, disease, injury or other cause, requires hospital services.

20(1) Sous réserve des paragraphes (2) et (3), une corporation hospitalière ne peut refuser d'admettre comme malade une personne qui nécessite des services hospitaliers en raison d'une maladie, d'un mal, d'une blessure ou pour un autre motif.

20(2) A hospital corporation may refuse to admit a person as a patient if the person's life is not

20(2) Une corporation hospitalière peut refuser d'admettre une personne comme malade si la vie

endangered by the refusal and if, in the opinion of the chief executive officer of the hospital corporation, or of the senior administrative officer of a hospital facility operated or maintained by the hospital corporation, based on competent medical advice,

(a) the condition of the person is such that the person does not require hospital services,

de cette personne n'est pas mise en danger en raison de ce refus et si, de l'avis du directeur général de la corporation hospitalière, ou de l'agent administratif senior d'un établissement hospitalier exploité ou maintenu par la corporation hospitalière, fondé sur un avis d'un médecin compétent,

a) en raison de son état, cette personne ne nécessite aucun service hospitalier,

(b) the hospital corporation or the hospital facility does not provide the hospital services required,

(c) the services of the hospital corporation or hospital facility and condition of the person are such that the hospital services required could be more effectively provided at a later date, or

(d) the condition of the person is such that the services required could be provided as effectively without admission.

20(3) A hospital corporation may refuse to admit a person as a patient if the person's life is not endangered by the refusal and if the hospital services required by the person are not entitled services under the *Hospital Services Act*.

21 If a patient who is an indigent person, or the dependant of an indigent person, dies in a hospital facility, the Minister of Human Resources Development shall pay to the hospital corporation, in accordance with the regulations, any expenses of burial incurred by the hospital corporation.

1994, c.59, s.6.

22(1) A hospital corporation shall not engage in any program to train persons in the medical and allied professions without the prior written approval of the Minister.

22(2) Despite subsection (1), a hospital corporation may engage in education programs designed to acquaint staff, servants and employees with new developments in their respective areas of expertise.

23(1) No action shall be brought against the Province, a hospital corporation, a member of the board of trustees of a hospital corporation or a person employed by a hospital corporation for damages for injury as a result of any negligence in

b) la corporation hospitalière ou l'établissement hospitalier ne dispense pas les services hospitaliers requis,

c) les services de la corporation hospitalière ou de l'établissement hospitalier et l'état de la personne sont tels que les services hospitaliers requis pourraient être dispensés plus efficacement à une date ultérieure, ou

d) en raison de l'état de cette personne, les services requis pourraient lui être dispensés tout aussi efficacement sans son admission comme malade.

20(3) Une corporation hospitalière peut refuser d'admettre une personne comme malade si la vie de la personne n'est pas mise en danger en raison de ce refus et si les services hospitaliers requis par cette personne ne sont pas des services assurés en vertu de la *Loi sur les services hospitaliers*.

21 Si un malade qui est un indigent ou une personne à charge d'un indigent décède dans un établissement hospitalier, le ministre du Développement des Ressources humaines doit rembourser à la corporation hospitalière les frais que celle-ci supporte pour l'enterrement de ce malade, conformément aux règlements.

1994, c.59, art.6.

22(1) Une corporation hospitalière ne peut réaliser un programme de formation de personnes aux professions médicales et paramédicales sans avoir obtenu au préalable l'autorisation écrite du Ministre.

22(2) Nonobstant le paragraphe (1), une corporation hospitalière peut s'engager dans des programmes de formation, destinés à familiariser les membres du personnel, les préposés et les employés à l'évolution respective de leurs spécialités.

23(1) L'action en dommages-intérêts à raison d'un préjudice causé par une négligence dans l'admission d'un malade, la dispensation des services hospitaliers à un malade ou la sortie d'un malade ne peut être intentée, contre la province, une cor-

*Chap. H-6.1**Loi hospitalière*

the admission of a patient, the delivery of hospital services to a patient or the discharge of a patient except within two years after the patient is discharged or ceases to receive hospital services, or within one year after the person bringing the action knew or ought to have known the facts upon which the person alleges negligence, whichever is later.

23(2) If a person entitled to bring an action is at the time the cause of action arises a minor, mentally incompetent or of unsound mind, the limitation period referred to in subsection (1) does not begin to run until the person reaches the age of majority or becomes mentally competent or of sound mind, as the case may be.

23(3) No action shall be brought against the individual members of the board of trustees of a hospital corporation acting honestly and in good faith.

23(4) Every member, and the heirs, executors, estate and effects of every member of the board of trustees of a hospital corporation shall be indemnified and saved harmless out of the funds of the hospital corporation with respect to all costs, charges and expenses that the member incurs in relation to any action or other proceeding brought or prosecuted against the member in connection with the duties of the person as a member of the board of trustees; and also with respect to all other costs, charges and expenses the member incurs in connection with those duties, except costs, charges and expenses that are occasioned by the member's own wilful neglect or wilful default.

24(1) A hospital corporation shall maintain a record for each patient in accordance with the regulations.

24(2) A hospital corporation shall maintain such additional records and shall make such reports and returns as are required by the regulations.

poration hospitalière, un membre du conseil de fiduciaires d'une corporation hospitalière ou une personne employée par une corporation hospitalière que dans les deux ans qui suivent la sortie du malade ou la cessation de la réception des services hospitaliers, ou bien dans l'année qui suit la date où la personne qui intente l'action a connu ou aurait dû connaître les faits qu'elle dénonce comme négligence, selon la dernière éventualité.

23(2) Lorsque la personne qui a droit d'intenter une action est, à la date où naît la cause d'action, mineure, incapable mentale ou privée de raison, le délai de prescription visé au paragraphe (1) ne commence à courir que lorsque cette personne atteint l'âge de la majorité ou devient capable mentale ou saine d'esprit, selon le cas.

23(3) Il ne peut être intenté d'action en dommages-intérêts contre les membres personnellement du conseil de fiduciaires d'une corporation hospitalière s'ils ont agi de bonne foi et en toute honnêteté.

23(4) Chaque membre du conseil de fiduciaires d'une corporation hospitalière, ses héritiers, ses exécuteurs, ses biens et ses effets doivent être en tout temps protégés et indemnisés par les fonds de la corporation hospitalière à l'égard de tous coûts, toutes charges et toutes dépenses que le membre supporte relativement à une action ou autre procédure intentée ou poursuivie contre lui en rapport avec ses fonctions comme membre du conseil de fiduciaires; et aussi à l'égard de tous autres coûts, de toutes autres charges et de toutes autres dépenses que le membre supporte en rapport avec ces fonctions, sauf les coûts, charges ou dépenses résultant de la propre négligence ou de la propre faute délibérée du membre.

24(1) Une corporation hospitalière doit tenir un dossier pour chaque malade conformément aux règlements.

24(2) Une corporation hospitalière doit tenir des dossiers supplémentaires et doit rédiger les rapports et les déclarations qui sont requis par les règlements.

*Hospital Act**Chap. H-6.1*

25(1) The fiscal year of a hospital corporation begins on the first day of April in one year and ends on the thirty-first day of March in the next year.

25(2) A hospital corporation shall

(a) maintain books, accounts and accounting systems and perform audits in accordance with the regulations.

(b) operate within the budget approved by the Minister under the *Hospital Services Act*.

(c) submit an annual report, including a financial statement in such form and containing such information as may be required by the Auditor General and an auditor's report on the financial statement, to the Minister on or before the thirty-first day of July in each year for the preceding fiscal year, and

(d) conduct such additional analysis in relation to any aspect of the operations of the hospital corporation, or of a hospital facility operated or maintained by the hospital corporation, as may be required by the Auditor General, and attach to the annual report the results of the analysis and such other information in relation to it as may be required by the Auditor General.

26(1) Subject to subsection (4), a hospital corporation shall maintain adequate insurance coverage for the protection of all property of the hospital corporation and for the protection of all property entrusted to the hospital corporation.

26(2) For the purposes of subsection (1), a hospital corporation shall be deemed to have an insurable interest in property entrusted to it.

26(3) The Province may assume responsibility for interests and risks of a hospital corporation respecting specified property of the hospital corporation and respecting specified property entrusted to the hospital corporation.

25(1) L'année financière d'une corporation hospitalière commence le 1^{er} avril d'une année et prend fin le 31 mars de l'année suivante.

25(2) Une corporation hospitalière doit

a) tenir des registres comptables, des livres de comptes et des systèmes de comptabilité et exécuter des vérifications conformément aux règlements,

b) exploiter selon le budget agréé par le Ministre en vertu de la *Loi sur les services hospitaliers*,

c) soumettre un rapport annuel, y compris un état financier selon la forme et contenant les renseignements qui peuvent être requis par le vérificateur général et un rapport du vérificateur sur les états financiers, au Ministre, le 31 juillet de chaque année ou avant cette date, pour l'année financière précédente, et

d) procéder à une analyse supplémentaire concernant tout aspect des activités de la corporation hospitalière, ou d'un établissement hospitalier exploité ou maintenu par une corporation hospitalière, selon ce que le vérificateur général peut exiger, et annexer au rapport annuel les résultats de l'analyse et d'autres renseignements y afférents que le vérificateur général peut exiger.

26(1) Sous réserve du paragraphe (4), une corporation hospitalière doit garder en vigueur une assurance convenable pour protéger tous les biens de la corporation hospitalière et pour protéger tous les biens confiés à la corporation hospitalière.

26(2) Aux fins du paragraphe (1), une corporation hospitalière est réputée avoir un intérêt assurable dans les biens qui lui sont confiés.

26(3) La province peut assumer la responsabilité quant aux droits et risques d'une corporation hospitalière à l'égard des biens spécifiques de la corporation hospitalière et à l'égard des biens spécifiques qui ont été confiés à la corporation hospitalière.

*Chap. H-6.1**Loi hospitalière*

26(4) If the Province assumes responsibility under subsection (3) respecting specified property, the hospital corporation shall not maintain insurance coverage for the protection of that property.

26(5) Any money payable as a result of damage to property of a hospital corporation, or to property entrusted to a hospital corporation, is payable to the owner or owners of the property in accordance with their interests.

26(6) If property of a hospital corporation, or property entrusted to a hospital corporation, is damaged, it shall not be repaired or abandoned without the prior written approval of the Minister.

26(7) If a hospital facility not owned by the Province is destroyed or significantly damaged, it shall not be replaced or repaired except as a hospital facility totally owned by the Province.

27(1) Subject to subsection (3), a hospital corporation shall maintain adequate insurance coverage for the protection of all patients, visitors, staff and other persons who are, by invitation, at buildings or other premises or places of or entrusted to the hospital corporation.

27(2) The Province may agree to indemnify a hospital corporation, on such terms and conditions as the Province considers appropriate, for any money payable by the hospital corporation to or in respect of patients, visitors, staff or other persons who are, by invitation, at buildings or other premises or places of or entrusted to the hospital corporation, as a result of liability incurred by the hospital corporation for injury or loss to such patients, visitors, staff or other persons.

27(3) If the Province has agreed under subsection (2) to indemnify a hospital corporation, the

26(4) Si la responsabilité en vertu du paragraphe (3) à l'égard des biens spécifiques est assumée par la province, la corporation hospitalière ne doit pas garder une assurance en vigueur sur ces biens.

26(5) Le paiement de toute somme d'argent pour des dommages causés à des biens d'une corporation hospitalière, ou à des biens confiés à la corporation hospitalière, doit être versé au propriétaire ou aux propriétaires des biens selon leurs droits.

26(6) Si les biens d'une corporation hospitalière, ou les biens confiés à la corporation hospitalière sont endommagés, ils ne doivent pas être réparés ou abandonnés sans l'autorisation préalable écrite du Ministre.

26(7) Un établissement hospitalier n'appartenant pas à la province qui est détruit ou a subi des dommages substantiels ne doit pas être remplacé ou réparé si ce n'est comme établissement hospitalier qui est la propriété entière de la province.

27(1) Sous réserve du paragraphe (3), une corporation hospitalière doit garder en vigueur une assurance convenable pour protéger les malades, les visiteurs, le personnel et les autres personnes qui se trouvent sur invitation dans les bâtiments ou autres lieux ou endroits de la corporation hospitalière ou confiés à celle-ci.

27(2) La Province peut, selon les modalités et conditions qu'elle estime appropriées, convenir d'indemniser une corporation hospitalière pour toute somme d'argent payable par elle directement ou relativement aux malades, aux visiteurs, au personnel ou aux autres personnes qui se trouvent sur invitation dans les bâtiments ou autres lieux ou endroits de la corporation hospitalière ou confiés à celle-ci, en conséquence de la responsabilité encourue par la corporation hospitalière pour blessure ou perte survenue à ces malades, ces visiteurs, ce personnel ou ces autres personnes qui s'y trouvent.

27(3) Lorsque la Province a convenu en vertu du paragraphe (2) d'indemniser une corporation hos-

*Hospital Act**Chap. H-6.1*

hospital corporation shall not maintain insurance coverage for the protection of patients, visitors, staff and other persons, who are, by invitation, at buildings or other premises or places of or entrusted to the hospital corporation.

28 There shall be a management committee consisting of such members as may be appointed from time to time by the Lieutenant-Governor in Council to advise the Minister

(a) on matters in relation to section 27, and

(b) on other matters referred to it by the Minister.

29(1) The Lieutenant-Governor in Council may appoint a trustee to whom and in whom shall be transferred and vested on the appointment, without further action, all rights, powers, duties and responsibilities of the board of trustees of a hospital corporation for such period as the Lieutenant-Governor in Council considers fit, if, in the opinion of the Minister, the board of trustees

(a) is not functioning effectively, or

(b) fails to comply or to ensure that the hospital corporation complies with any provision of this Act or the regulations, or with parameters established or directions issued by the Minister, within the period of time specified by the Minister at the time the Minister notifies the board of trustees of the requirement to comply.

29(2) If satisfied that the reason for appointing a trustee under subsection (1) no longer exists, the Lieutenant-Governor in Council may terminate the appointment of the trustee and all rights, powers, duties and responsibilities transferred to and vested in or acquired by the trustee are, without further action, transferred to and re-vested or vested in the board of trustees of the hospital corporation on the termination.

pitalière, la corporation hospitalière ne doit pas garder une assurance pour la protection des malades, des visiteurs, du personnel et d'autres personnes qui se trouvent sur invitation dans les bâtiments ou autres lieux ou endroits de la corporation hospitalière ou qui sont confiés à celle-ci.

28 Il est créé un comité de gestion composé de membres que le lieutenant-gouverneur en conseil peut nommer de temps à autre pour conseiller le Ministre

a) sur les questions relatives à l'article 27, et

b) sur les autres questions que le Ministre peut renvoyer au comité.

29(1) Le lieutenant-gouverneur en conseil peut nommer un fiduciaire à qui doivent être transférés et dévolus, dès sa nomination, et sans autres formalités, tous les droits, tous les pouvoirs, toutes les fonctions et toutes les responsabilités du conseil de fiduciaires d'une corporation hospitalière, pour la période que le lieutenant-gouverneur en conseil estime appropriée lorsque, de l'avis du Ministre, le conseil de fiduciaires

a) ne fonctionne pas efficacement, ou

b) fait défaut de se conformer ou de veiller à ce que la corporation hospitalière se conforme à toute disposition de la présente loi ou des règlements, ou aux paramètres établis par le Ministre ou aux directives délivrées par le Ministre, dans les délais précisés par le Ministre, au moment où le Ministre avise le conseil de fiduciaires de s'y conformer.

29(2) Lorsque le lieutenant-gouverneur en conseil est convaincu que les motifs de la nomination d'un fiduciaire en vertu du paragraphe (1) n'existent plus, il peut révoquer cette nomination, et dès lors, tous les droits, tous les pouvoirs, toutes les fonctions et toutes les responsabilités transférés et dévolus au fiduciaire ou acquis par celui-ci sont, sans autres formalités, transférés et dévolus à nouveau ou dévolus au conseil de fiduciaires de la corporation hospitalière.

Chap. H-6.1

Loi hospitalière

29(3) Subsection 23(4) applies to a trustee appointed under this section.

30(1) If an existing hospital facility ceases to be used as a hospital facility and is replaced by a hospital facility owned by the Province, effective on the date the existing hospital facility ceases to be used as a hospital facility

(a) all property, except property referred to in paragraph (b), and all debts and liabilities associated with the existing hospital facility are, without further action, transferred to and vested in the hospital corporation that will be responsible for the operation and maintenance of the hospital facility owned by the Province, and

(b) the existing hospital facility, including all land, buildings, building service equipment, staff residences and other facilities associated with the existing hospital facility, are, without further action, transferred to and vested in the Minister of Supply and Services as a representative of the Crown in right of the Province.

30(2) If an existing hospital facility owned by the Province ceases to be used as a hospital facility and is not replaced by another hospital facility, effective on the date the existing hospital facility ceases to be used as a hospital facility

(a) all property, except property referred to in paragraph (b), and all debts and liabilities associated with the existing hospital facility are, without further action, transferred to and vested in the Minister as a representative of the Crown in right of the Province, and

(b) the existing hospital facility, including all land, buildings, building service equipment, staff residences and other facilities associated with the existing hospital facility, are, without further action, transferred to and vested in the

29(3) Le paragraphe 23(4) s'applique à un fiduciaire nommé en vertu du présent article.

30(1) Si un établissement hospitalier existant cesse d'être utilisé comme établissement hospitalier et qu'il est remplacé par un établissement hospitalier appartenant à la province, à compter de la date où l'établissement hospitalier existant cesse d'être utilisé comme établissement hospitalier

a) tous les biens, à l'exception de ceux mentionnés à l'alinéa b), et toutes les dettes et obligations liées à l'établissement hospitalier existant sont, sans autres formalités, transférées et dévolues à la corporation hospitalière qui sera responsable de l'exploitation et du maintien de l'établissement hospitalier appartenant à la province, et

b) l'établissement hospitalier existant, y compris, tous terrains, tous bâtiments, toute installation matérielle des bâtiments, toutes résidences du personnel et tous autres établissements connexes à l'établissement hospitalier existant, sont, sans autres formalités, transférées et dévolues au ministre de l'Approvisionnement et des Services en sa qualité de représentant de la Couronne du chef de la province.

30(2) Si un établissement hospitalier existant appartenant à la province cesse d'être utilisé comme établissement hospitalier et qu'il n'est pas remplacé par un autre établissement hospitalier, à compter de la date où l'établissement hospitalier cesse d'être utilisé comme établissement hospitalier

a) tous les biens, à l'exception de ceux mentionnés à l'alinéa b), et toutes les dettes et obligations liées à l'établissement hospitalier existant sont, sans autres formalités, transférées et dévolues au Ministre à titre de représentant de la Couronne du chef de la province, et

b) l'établissement hospitalier existant, y compris tous terrains, tous bâtiments, toute installation matérielle des bâtiments, toutes résidences du personnel et tous autres établissements connexes à l'établissement hospitalier existant,

*Hospital Act**Chap. H-6.1*

Minister of Supply and Services as a representative of the Crown in right of the Province.

sont, sans autres formalités, transférées et dévolues au ministre de l'Approvisionnement et des Services en sa qualité de représentant de la Couronne du chef de la province.

30(3) If an existing hospital facility not owned by the Province ceases to be used as a hospital facility and is not replaced by another hospital facility, effective on the date the existing hospital facility ceases to be used as a hospital facility

30(3) Si un établissement hospitalier existant qui n'appartient pas à la province cesse d'être utilisé comme établissement hospitalier et qu'il n'est pas remplacé par un autre établissement hospitalier, à compter de la date où l'établissement hospitalier existant cesse d'être utilisé comme établissement hospitalier

(a) all property supplied in relation to the existing hospital facility by the Province is, without further action, transferred to and vested in the Minister as a representative of the Crown in right of the Province, and the Minister has the right to remove the property, and

a) tous les biens que la province a fournis relativement à l'établissement hospitalier existant sont, sans autres formalités, transférés et dévolus au Ministre à titre de représentant de la Couronne du chef de la province, et le Ministre a le droit de déplacer les biens, et

(b) the Minister of Supply and Services as a representative of the Crown in right of the Province has the right of first refusal to purchase the existing hospital facility, including all land, buildings, building service equipment, staff residences and other facilities associated with the existing hospital facility.

b) le ministre de l'Approvisionnement et des Services en sa qualité de représentant de la Couronne du chef de la province, bénéficie d'un droit de préemption sur l'achat de l'établissement hospitalier existant, y compris tous les terrains, tous les bâtiments, toute installation matérielle des bâtiments, toutes résidences du personnel et tous autres établissements connexes à l'établissement hospitalier existant.

30(4) For the purposes of this section, the date on which a hospital facility ceases to be used as a hospital facility is the date determined by the Lieutenant-Governor in Council.

30(4) Aux fins du présent article, la date où un établissement hospitalier cesse d'être utilisé comme établissement hospitalier est la date fixée par le lieutenant-gouverneur en conseil.

30(5) Paragraphs (1)(b), (2)(b) and (3)(b) do not apply unless the order-in-council determining the date the existing hospital facility ceases to be used as a hospital facility states that they apply.

30(5) Les alinéas (1)b), (2)b) et (3)b) ne s'appliquent pas à moins que le décret en conseil fixant la date où l'établissement hospitalier existant cesse d'être utilisé comme établissement hospitalier stipule qu'ils s'appliquent.

30(6) An order-in-council issued under this section is not a regulation within the meaning of the *Regulations Act*.

30(6) Un décret en conseil délivré en vertu du présent article ne constitue pas un règlement au sens de la *Loi sur les règlements*.

31(1) Subject to section 32, no action, application or other proceeding lies or shall be instituted against the Minister or the Crown in right of the Province in respect of the transfer and vesting of rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties, responsibilities,

31(1) Sous réserve de l'article 32, nulle action, demande ou autre procédure n'existe ni ne peut être engagée contre le Ministre ou la Couronne du chef de la province à l'égard du transfert et de la dévolution des droits, pouvoirs, privilèges, franchises, titres, dettes, obligations, engagements,

Chap. H-6.1

Loi hospitalière

ties, property or interests in property by this Act or the regulations.

31(2) Without restricting the generality of subsection (1), no action, application or other proceeding for dismissal, whether express, implied or constructive, lies or shall be instituted against the Minister or the Crown in right of the Province in respect of any transfer or vesting of rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties or responsibilities by this Act or the regulations.

31(3) Nothing in subsections (1) and (2) affects any right or remedy an employee has under a collective agreement, an Act of the Legislature, regulations under an Act of the Legislature, or the common law.

32(1) This Act and the regulations supersede the *Expropriation Act*.

32(2) The Minister, in relation to property transferred to and vested in a body corporate, the Minister or the Minister of Supply and Services by this Act or the regulations, may provide compensation that, in the opinion of the Minister, fairly reflects, subject to subsection (3), the value of an owner's interest in or contribution to the property.

32(3) In determining the compensation to be provided under this section, the value of contributions by the Province to the property shall be set off against a claim for compensation.

32(4) A person who claims to be entitled to compensation under this section shall deliver to the Minister a written claim setting out full particulars of the claim and of the person's right and title to compensation.

32(5) If the Minister does not agree with the compensation claimed under subsection (4), the Minister shall offer in writing the amount the Minister considers to fairly reflect, subject to subsection (3), the value of the person's interest in or contribution to the property and at the same time give notice to the person that, if the amount of the offer is not accepted, the matter will be submitted to arbitration.

fonctions, responsabilités, biens ou droits dans les biens par la présente loi ou les règlements.

31(2) Sans restreindre la portée du paragraphe (1), nulle action, demande ou autre procédure pour révocation, soit expresse, implicite ou par interprétation, n'existe ou ne peut être engagée contre le Ministre ou la Couronne du chef de la province à l'égard du transfert ou de la dévolution des droits, pouvoirs, privilèges, concessions, titres, dettes, obligations, engagements, fonctions ou responsabilités par la présente loi ou les règlements.

31(3) Rien aux paragraphes (1) et (2) ne porte atteinte à un droit ou recours qu'un employé a en vertu d'une convention collective, d'une loi de la Législature, des règlements établis en vertu d'une loi de la Législature, ou de la common law.

32(1) La présente loi et les règlements ont priorité sur la *Loi sur l'expropriation*.

32(2) Le Ministre peut, relativement aux biens transférés et dévolus à un corps constitué, au Ministre ou au ministre de l'Approvisionnement et des Services en vertu de la présente loi ou des règlements, donner une indemnité qui, de l'avis du Ministre, reflète de façon juste, sous réserve du paragraphe (3), la valeur d'un droit de propriétaire ou d'une contribution dans les biens.

32(3) En fixant l'indemnité à donner en vertu du présent article, la valeur des contributions par la province dans les biens doit être compensée à l'encontre de la réclamation d'indemnité.

32(4) Une personne qui estime avoir droit à une indemnité en vertu du présent article doit remettre au Ministre une réclamation écrite établissant tous les renseignements au sujet de sa réclamation ainsi que son droit et son titre à cette indemnité.

32(5) Si le Ministre n'est pas d'accord avec l'indemnité réclamée en vertu du paragraphe (4), il doit offrir par écrit le montant qui, de l'avis du Ministre, reflète de façon juste, sous réserve du paragraphe (3), la valeur du droit du réclamant ou sa contribution dans les biens et, en même temps, l'aviser que si le montant offert n'est pas accepté, la question sera soumise à l'arbitrage.

32(6) If an offer of the Minister under subsection (5) is not accepted within the period of time fixed by the Minister in the written offer, or within such further time as is agreed to by the Minister and the person claiming compensation, the Minister or the person claiming compensation may submit the matter of compensation to arbitration.

32(7) If the Minister or the person claiming compensation submits the matter of compensation to arbitration, the Minister and the person shall be deemed to have entered into a written arbitration agreement and the *Arbitration Act* applies.

33(1) A person who violates or fails to comply with any provision of the regulations commits an offence.

33(2) A person who violates or fails to comply with a provision of this Act that is listed in Column I of Schedule A commits an offence.

33(3) For the purposes of Part II of the *Provincial Offences Procedure Act*, each offence listed in Column I of Schedule A is punishable as an offence of the category listed beside it in Column II of Schedule A.

34(1) The Minister is responsible for the administration of this Act and the regulations.

34(2) The Minister may designate persons to act on behalf of the Minister for the purposes of this Act and the regulations.

34(3) The Minister may establish parameters and issue directions in relation to the planning, organization, management and delivery of hospital services by hospital corporations.

34(4) The Minister may make an approval given by the Minister under this Act or the regulations subject to such terms and conditions as the Minister considers appropriate.

32(6) Si l'offre du Ministre en vertu du paragraphe (5) n'est pas acceptée dans le délai fixe par le Ministre dans l'offre écrite, ou dans le délai supplémentaire convenu par le Ministre et le réclamant, le Ministre ou le réclamant peut soumettre cette question d'indemnité à l'arbitrage.

32(7) Si le Ministre ou la personne qui réclame l'indemnité soumet la question de l'indemnité à l'arbitrage, le Ministre et le réclamant sont réputés avoir conclu une convention d'arbitrage écrite et la *Loi sur l'arbitrage* s'applique.

33(1) Quiconque contrevient ou omet de se conformer à une disposition des règlements commet une infraction.

33(2) Quiconque contrevient ou omet de se conformer à une disposition de la présente loi qui est mentionnée dans la Colonne I de l'Annexe A commet une infraction.

33(3) Aux fins de la Partie II de la *Loi sur la procédure applicable aux infractions provinciales*, chaque infraction mentionnée dans la Colonne I de l'Annexe A est punissable à titre d'infraction de la classe mentionnée à côté d'elle à la Colonne II de l'Annexe A.

34(1) Le Ministre est chargé de l'application de la présente loi et des règlements.

34(2) Le Ministre peut désigner des personnes pour le représenter aux fins de la présente loi et des règlements.

34(3) Le Ministre peut établir les paramètres et délivrer des directives relativement à la planification, à l'organisation, à la gestion et à la dispensation des services hospitaliers par les corporations hospitalières.

34(4) Le Ministre peut assujettir toute autorisation donnée par le Ministre en vertu de la présente loi ou des règlements aux modalités et conditions que le Ministre estime appropriées.

*Chap. H-6.1**Loi hospitalière*

34(5) The Minister may suspend or revoke an approval given under this Act or the regulations.

34(6) A designation made, a parameter or guideline established, a direction issued, a provision specified or an approval given, suspended or revoked by the Minister under this Act or the regulations is not a regulation within the meaning of the *Regulations Act*.

1993, c.63, s.2.

35(1) The Lieutenant-Governor in Council may make regulations

(a) establishing bodies corporate for the purposes of this Act and the regulations, including

(i) providing for the interim management of newly established bodies corporate, including the appointment of the members of the first board of trustees, and

(ii) providing for all other matters ancillary to the establishment of bodies corporate for the purposes of this Act and the regulations;

(b) designating bodies corporate not established by this Act or the regulations as hospital corporations for the purposes of this Act and the regulations;

(c) transferring responsibility for hospital facilities from one hospital corporation to another, including transferring and vesting, without further action, property and interests in property, except land, buildings and building service equipment, that is used for or in connection with or that relates to the hospital facilities, or that is associated with the establishment, operation or maintenance of the hospital facilities, and transferring and vesting, without further action, all rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities, whether es-

34(5) Le Ministre peut suspendre ou révoquer une autorisation donnée en vertu de la présente loi ou des règlements.

34(6) Une désignation qui est faite, un paramètre ou des lignes directrices qui sont établis, une directive qui est délivrée, une disposition qui est précisée ou une autorisation qui est donnée, suspendue ou révoquée par le Ministre en vertu de la présente loi ou des règlements ne constituent pas un règlement au sens de la *Loi sur les règlements*.

1993, c.63, art.2.

35(1) Le lieutenant-gouverneur en conseil peut établir des règlements

a) établissant des corps constitués aux fins de la présente loi et des règlements, y compris

(i) prévoyant la gestion provisoire des corps constitués nouvellement établis, y compris la nomination des membres du premier conseil de fiduciaires, et

(ii) prévoyant toutes les autres questions accessoires à l'établissement des corps constitués aux fins de la présente loi et des règlements;

b) désignant des corps constitués non établis par la présente loi ou les règlements à titre de corporations hospitalières aux fins de la présente loi et des règlements;

c) effectuant le transfert de la responsabilité pour des établissements hospitaliers à partir d'une corporation hospitalière à une autre, y compris effectuant le transfert et la dévolution, sans autres formalités, des biens et des droits dans les biens, sauf les terrains, bâtiments et l'installation matérielle des bâtiments qui sont utilisés pour les établissements hospitaliers ou en connexion avec ces établissements ou qui se rapportent à ces établissements, ou qui sont associés à l'établissement, à l'exploitation ou au maintien des établissements hospitaliers, et effectuant le transfert et la dévolution, sans

established or assigned by an Act of the Legislature, by articles of incorporation, by letters patent, by by-laws or by any other document or instrument, that relate to the hospital facilities or that are associated with the establishment, operation and maintenance of the hospital facilities;

(d) respecting criteria, including the distribution and composition of population within a region, to be considered in the appointment and selection of members of boards of trustees of hospital corporations;

(e) limiting the number of or portion of members of the board of trustees of a hospital corporation from the largest urban centre within a region;

(f) respecting the appointment or selection of members of boards of trustees of hospital corporations, including the terms of office of members and the maximum number of years that members may serve;

(g) respecting the criteria on which the eligibility of a person to be a member of a board of trustees of a hospital corporation is to be determined;

(h) respecting conflicts of interest pertaining to members of boards of trustees of hospital corporations, including the circumstances that constitute a conflict of interest, the disclosure of a conflict of interest and the manner in which a conflict of interest is to be dealt with;

(i) providing for the appointment of members of boards of trustees of hospital corporations in lieu of the members in relation to whom the selection or appointment authority ceases to exist;

autres formalités, des droits, pouvoirs, privilèges, concessions, titres, dettes, obligations, engagements, fonctions et responsabilités qu'ils soient établis ou assignés par une loi de la Législature, statuts corporatifs, lettres patentes, règlements administratifs ou par un autre document ou instrument, qui se rapportent aux établissements hospitaliers ou qui sont associés à l'établissement, à l'exploitation et au maintien des établissements hospitaliers;

d) concernant les critères à considérer, y compris la répartition et la composition de la population dans une région, en vue de la nomination et du choix des membres des conseils de fiduciaires des corporations hospitalières;

e) limitant le nombre ou la partie des membres du conseil de fiduciaires d'une corporation hospitalière du plus grand centre urbain dans une région;

f) concernant la nomination ou le choix des membres des conseils de fiduciaires des corporations hospitalières, y compris les mandats des membres et le nombre maximal d'années pendant lesquelles ces membres peuvent être en fonction;

g) concernant les critères selon lesquels l'admissibilité d'une personne comme membre d'un conseil de fiduciaires d'une corporation hospitalière doit être déterminée;

h) concernant les conflits d'intérêt au sujet des membres des conseils de fiduciaires des corporations hospitalières, y compris les circonstances qui constituent un conflit d'intérêt, la divulgation d'un conflit d'intérêt et la manière selon laquelle un conflit d'intérêt doit être traité;

i) prévoyant la nomination des membres des conseils de fiduciaires des corporations hospitalières remplaçant ceux qui relèvent, quant à leur choix et nomination, de l'autorité qui cesse d'exister;

- (i.1) respecting the number of members for the advisory committees referred to in subsection 15.1(1);
- (i.2) respecting the designation of chairpersons for the advisory committees referred to in subsection 15.1(1), and the payment of honorariums to the chairpersons;
- (i.3) respecting the reimbursement of the members of the advisory committees referred to in subsection 15.1(1) for expenses incurred by them as members of the advisory committees;
- (i.4) respecting the reimbursement of the advisory committees referred to in subsection 15.1(1) for expenses incurred by the advisory committees in exercising their powers and carrying out their duties under this Act and the regulations;
- (i.5) authorizing the Minister to establish guidelines
- (i) for the payment of honorariums to the chairpersons of the advisory committees referred to in subsection 15.1(1), and
- (ii) for the reimbursement of the advisory committees referred to in subsection 15.1(1) and the members of those committees for the expenses referred to in paragraphs (i.3) and (i.4);
- (i.6) prescribing additional powers and duties for the advisory committees referred to in subsection 15.1(1);
- (i.7) respecting access by the advisory committees referred to in subsection 15.1(1) to hospital corporation personnel and to hospital corporation and hospital facility records for purposes directly related to the powers and duties of the advisory committees under this Act and the regulations;
- i.1) concernant le nombre des membres des comités consultatifs prévus au paragraphe 15.1(1);
- i.2) concernant la désignation des présidents des comités consultatifs prévus au paragraphe 15.1(1) et le versement d'honoraires aux présidents;
- i.3) concernant le remboursement aux membres des comités consultatifs prévus au paragraphe 15.1(1) des dépenses encourues par eux à titre de membres des comités consultatifs;
- i.4) concernant le remboursement aux comités consultatifs prévus au paragraphe 15.1(1) des dépenses encourues par les comités consultatifs dans l'exercice de leurs pouvoirs et dans l'exécution de leurs fonctions en vertu de la présente loi et des règlements;
- i.5) autorisant le Ministre à établir des lignes directrices
- (i) pour le versement d'honoraires aux présidents des comités consultatifs prévus au paragraphe 15.1(1), et
- (ii) pour le remboursement aux comités consultatifs prévus au paragraphe 15.1(1) et aux membres de ces comités des dépenses visées aux alinéas i.3) et i.4);
- i.6) prescrivant les pouvoirs et fonctions additionnels des comités consultatifs prévus au paragraphe 15.1(1);
- i.7) concernant l'accès des comités consultatifs prévus au paragraphe 15.1(1) au personnel de la corporation hospitalière et aux dossiers de la corporation hospitalière et de l'établissement hospitalier aux fins qui sont directement reliées aux pouvoirs et aux fonctions des comités consultatifs en vertu de la présente loi et des règlements;

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| <p><i>(j)</i> respecting the appointment, powers, privileges and duties of officers, chief executive officers, medical staff and other staff and employees of hospital corporations;</p> <p><i>(k)</i> respecting the establishment, construction, alteration, operation, maintenance and repair of hospital facilities;</p> <p><i>(l)</i> respecting equipment in hospital facilities;</p> <p><i>(m)</i> respecting safety in hospital facilities;</p> <p><i>(n)</i> respecting the classification and grading of hospital corporations and hospital facilities;</p> <p><i>(o)</i> respecting standards for hospital facilities and hospital services;</p> <p><i>(p)</i> respecting the inspection, control, government, management, conduct, operation and use of hospital facilities;</p> <p><i>(q)</i> respecting the admission, care, conduct and discharge of patients or any class of patients;</p> <p><i>(r)</i> respecting the classification of patients;</p> <p><i>(s)</i> respecting records to be maintained for patients, including the contents of the records, the preparation, maintenance, storage, removal and destruction of the records and the confidentiality and disclosure of the records;</p> <p><i>(t)</i> respecting additional records to be maintained, and reports and returns to be made by hospital corporations;</p> <p><i>(u)</i> respecting books, accounts and accounting systems to be maintained and the audits to be performed by hospital corporations;</p> | <p><i>j)</i> concernant la nomination, les pouvoirs, privilèges et fonctions des dirigeants, directeurs généraux, membres du personnel médical et autres membres du personnel et des employés des corporations hospitalières;</p> <p><i>k)</i> concernant l'établissement, la construction, la modification, l'exploitation, l'entretien et la réparation des établissements hospitaliers;</p> <p><i>l)</i> concernant l'équipement des établissements hospitaliers;</p> <p><i>m)</i> concernant la sécurité dans les établissements hospitaliers;</p> <p><i>n)</i> concernant la classification et les catégories des corporations hospitalières et des établissements hospitaliers;</p> <p><i>o)</i> concernant les normes pour les établissements hospitaliers et les services hospitaliers;</p> <p><i>p)</i> concernant l'inspection, le contrôle, la direction, la gestion, la marche, l'exploitation et l'usage des établissements hospitaliers;</p> <p><i>q)</i> concernant l'admission, les soins, la conduite et la sortie des malades ou d'une catégorie de malades;</p> <p><i>r)</i> concernant le classement des malades;</p> <p><i>s)</i> concernant les dossiers à tenir à l'égard des malades y compris leur contenu, préparation, maintien, entreposage, déplacement et destruction, ainsi que leur caractère confidentiel et leur divulgation;</p> <p><i>t)</i> concernant les registres supplémentaires à tenir et les rapports et relevés que les corporations hospitalières doivent effectuer;</p> <p><i>u)</i> concernant les registres, livres de comptes et les systèmes de comptabilité à tenir et les vérifications à effectuer par les corporations hospitalières;</p> |
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- (v) prescribing the classes of grants and the methods of determining the amounts of grants and providing for the manner and times of payment and the suspension and withholding of grants and for the making of deductions from grants;
- (w) prescribing additional matters as objects and purposes of bodies corporate established under this Act or the regulations;
- (x) requiring the board of trustees of a hospital corporation to include in the bylaws of the hospital corporation provisions specified by the Minister to ensure the preservation in a hospital facility owned in whole or in part by a religious order of the philosophy, values and mission that have been associated with the delivery of hospital services in that hospital facility;
- (y) defining words and expressions used but not defined in this Act;
- (z) transferring to and vesting, without further action, in the Minister of Supply and Services, as a representative of the Crown in right of the Province, for use as or for the purposes of hospital facilities any land, building or building service equipment that is not owned by the Province and that is used for or in connection with or that relates to hospital facilities or hospital services, or that is associated with the establishment, operation or maintenance of a hospital facility;
- (aa) exempting, subject to such terms and conditions as may be established in the regulations, any person, hospital corporation or hospital facility from the application of this Act
- v) prescrivant les catégories de subventions et les modes de fixation des montants des subventions et prévoyant la manière et les modalités de paiement, la suspension et la retenue des subventions et les déductions sur les subventions;
- w) prescrivant les questions additionnelles relatives aux objets et buts des corps constitués établis en vertu de la présente loi ou des règlements;
- x) requérant le conseil de fiduciaires d'une corporation hospitalière d'inclure dans les règlements administratifs de la corporation hospitalière des dispositions précisées par le Ministre pour assurer la préservation dans un établissement hospitalier appartenant en tout ou en partie à une communauté religieuse, de la philosophie, des valeurs et des objectifs généraux qui ont été associés à la dispensation des services hospitaliers dans cet établissement hospitalier;
- y) définissant des mots et expressions utilisés dans la présente loi, mais qui n'y sont pas définis;
- z) effectuant le transfert et la dévolution, sans autres formalités, au ministre de l'Approvisionnement et des Services, à titre de représentant de la Couronne du chef de la province, pour être utilisés comme établissements hospitaliers ou aux fins de ceux-ci, de tous terrains, de tous bâtiments ou de toutes installations matérielles des bâtiments qui n'appartiennent pas à la province et qui sont utilisés pour les établissements hospitaliers ou les services hospitaliers ou en connexion avec ces établissements ou services ou qui se rapportent à ces établissements ou services, ou qui sont associés à l'établissement, à l'exploitation ou au maintien d'un établissement hospitalier;
- aa) exemptant, sous réserve des modalités et conditions qui peuvent être établies dans les règlements, toute personne, toute corporation hospitalière ou tout établissement hospitalier de

*Hospital Act**Chap. H-6.1*

and the regulations, or from the application of any provision of this Act or the regulations.

l'application de la présente loi et des règlements, ou de l'application de toute disposition de la présente loi ou des règlements.

35(2) The Lieutenant-Governor in Council may declare, for such time or times as the Lieutenant-Governor in Council considers appropriate, all or any of the regulations to be in force with respect only to

35(2) Le lieutenant-gouverneur en conseil peut déclarer, pour la période ou les périodes qu'il estime appropriées, que tous les règlements ou l'un d'entre eux ne soient en vigueur à l'égard seulement

(a) any one or more hospital corporations or hospital facilities,

a) d'une ou de plusieurs corporations hospitalières ou d'un ou de plusieurs établissements hospitaliers,

(b) any one or more classes of hospital corporations or hospital facilities.

b) d'une ou de plusieurs catégories de corporations hospitalières ou d'établissements hospitaliers.

1993, c.63, s.3.

1993, c.63, art.3.

36(1) *Despite sections 4 and 39, nothing in sections 1 to 35 or in the regulations affects CENTRACARE SAINT JOHN INC., its governing body or its officers until April 1, 1993, on and after which date sections 1 to 35 and the regulations apply with respect to CENTRACARE SAINT JOHN INC., its governing body and its officers.*

36(1) *Nonobstant les articles 4 et 39, rien dans les articles 1 à 35 ou dans les règlements n'influe sur CENTRACARE SAINT JOHN INC., son conseil d'administration ou ses dirigeants jusqu'au 1^{er} avril 1993, soit la date à partir de laquelle les articles 1 à 35 et les règlements s'appliquent à l'égard de CENTRACARE SAINT JOHN INC., son conseil d'administration et ses dirigeants.*

36(2) *Despite section 38, until the end of March 31, 1993 the Public Hospitals Act, chapter P-23 of the Revised Statutes, 1973, and the regulations under that Act, subject to section 20 of the Mental Health Commission of New Brunswick Act, apply to CENTRACARE SAINT JOHN INC., its governing body and its officers as though this Act had not come into force.*

36(2) *Nonobstant l'article 38, jusqu'à l'expiration du 31 mars 1993, la Loi sur les hôpitaux publics, chapitre P-23 des Lois révisées de 1973 et les règlements établis en vertu de cette Loi, sous réserve de l'article 20 de la Loi sur la Commission de la santé mentale du Nouveau-Brunswick, s'applique à CENTRACARE SAINT JOHN INC., son conseil d'administration et ses dirigeants comme si la présente loi n'était pas entrée en vigueur.*

37(1) *Despite sections 7 and 39, nothing in sections 1 to 35 or in the regulations affects CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC., its governing body or its officers until April 1, 1993, on and after which date sections 1 to 35 and the regulations apply with respect to CENTRE HOSPITALIER RESTIGOUCHE INC./RESTI-*

37(1) *Nonobstant les articles 7 et 39, rien dans les articles 1 à 35 ou dans les règlements n'influe sur le CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC., son conseil d'administration ou ses dirigeants jusqu'au 1^{er} avril 1993, soit la date à partir de laquelle les articles 1 à 35 et les règlements s'appliquent à l'égard du CENTRE HOS-*

Chap. H-6.1

Loi hospitalière

GOUCHE HOSPITAL CENTER INC., its governing body and its officers.

37(2) *Despite section 38, until the end of March 31, 1993 the Public Hospitals Act, chapter P-23 of the Revised Statutes, 1973, and the regulations under that Act, subject to section 20 of the Mental Health Commission of New Brunswick Act, apply to CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC., its governing body and its officers as though this Act had not come into force.*

38 *The Public Hospitals Act, chapter P-23 of the Revised Statutes, 1973, is repealed.*

39(1) *Subject to subsection (2), this Act comes into force on July 1, 1992.*

39(2) *Section 1, subsections 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1) and 9(1) and sections 10, 11, 12, 13, 14, 15, 34 and 35 come into force on Royal Assent.*

PITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC., de son conseil d'administration et de ses dirigeants.

37(2) *Nonobstant l'article 38, jusqu'à l'expiration du 31 mars 1993, la Loi sur les hôpitaux publics, chapitre P-23 des Lois révisées de 1973, et les règlements établis en vertu de cette loi, sous réserve de l'article 20 de la Loi sur la Commission de la santé mentale du Nouveau-Brunswick, s'applique au CENTRE HOSPITALIER RESTIGOUCHE INC./RESTIGOUCHE HOSPITAL CENTER INC., à son conseil d'administration et à ses dirigeants comme si la présente loi n'était pas entrée en vigueur.*

38 *La Loi sur les hôpitaux publics, chapitre P-23 des Lois révisées de 1973, est abrogée.*

39(1) *Sous réserve du paragraphe (2), la présente loi entre en vigueur le 1er juillet 1992.*

39(2) *L'article 1, les paragraphes 2(1), 3(1), 4(1), 5(1), 6(1), 7(1), 8(1), et 9(1) et les articles 10, 11, 12, 13, 14, 15, 34 et 35 entrent en vigueur sur sanction royale.*

SCHEDULE A

Column I Section	Column II Category of Offence
16(1)	E
16(2)	E
16(3)	F
16(4)	C
16(5)	F
17	F
20(1)	E
22(1)	F
24(1)	E
24(2)	C
25(2)	C
26(1)	C
27(1)	C
33(1)	B

N.B. This Act is consolidated to September 30, 1996.

ANNEXE A

Colonne I Article	Colonne II Classe d'infractions
16(1)	E
16(2)	E
16(3)	F
16(4)	C
16(5)	F
17	F
20(1)	E
22(1)	F
24(1)	E
24(2)	C
25(2)	C
26(1)	C
27(1)	C
33(1)	B

N.B. La présente loi est refondue au 30 septembre 1996.

APPENDIX C

LETTER OF UNDERSTANDING AND AGREEMENT

APPENDIX C

A G R E E M E N T

between

PROVINCE OF NEW BRUNSWICK
and
NEW BRUNSWICK CATHOLIC HEALTH ASSOCIATION
LA CONGRÉGATION DES FILLES DE JÉSUS
SISTER OF CHARITY OF THE IMMACULATE CONCEPTION
LES RELIGIEUSES DE NOTRE-DAME DU SACRÉ-COUR
RELIGIOUS HOSPITALERS OF ST. JOSEPH
LES RELIGIEUSES HOSPITALIÈRES DE SAINT-JOSEPH

AGREEMENT COMPONENTS

On April 21, 1993, the Catholic Religious Orders, the N.B. Catholic Health Association and the Province of New Brunswick signed a Letter of Understanding that outlined the various actions that would be taken so that the Province would be able to make use, within the context of the Province's Hospital System Master Plan, of the hospital facilities operated by the Orders prior to April, 1992.

The components of the overall agreement consist of:

1. the Letter of Understanding
2. the amendments to the Hospital Act and Regulations
3. the lease for each hospital facility
4. the facility administrator job description
5. arrangements for annual payments in relation to the advisory committees' functions, etc.
6. a letter of comfort regarding the hospital Act, Section 15.1(5) and (6), and Section 32.1(3) (a) and (b).
7. required By-Law wording for Region Hospital Corporation
8. terms of reference for Advisory Committees

The actions referred to in the Letter of Understanding were:

- A. Amendment of the Hospital Act and Regulations to establish advisory committees and specify their powers and duties.
- B. In addition to a nominal annual payment to each Order, payment by the Province of New Brunswick to the advisory committees, on an annual basis, for specified purposes, and subject to any terms and conditions specified in the Hospital Act and Regulations.
 - (i) reimbursement of the members of the advisory committee for expenses incurred by them as members of the advisory committees
 - (ii) reimbursement of the advisory committees for expenses incurred by the advisory committees in exercising their powers and carrying out their duties under the Act and the Regulations.
 - (iii) payment of an honorarium to the chairpersons of the advisory committees.
 - (iv) payment of a grant to the lessors to maintain active institutional memberships in the New Brunswick Catholic Health Association and the Catholic Health Association of Canada.

Once a lease has been signed for each facility involved, the total funding that would be provided for the above items would be \$150,000 annually. This amount would be provided to the Association for distribution on the basis of a methodology agreed to by the Association and the orders.

C. Signing of leases for use of the hospital facilities in question.

D. Establishment of a job description for the administrators of the hospital facilities in question.

In addition to the above, the Letter of Understanding also referred to amendment of the Hospital Act and Regulations to permit privately owned and operated hospital facilities to operate in the province, under specified terms and conditions.

APPENDIX C

PROVINCE OF NEW BRUNSWICK AS
REPRESENTED BY THE MINISTER OF
HEALTH AND COMMUNITY SERVICES

Russell H. T. King
Honourable Russell H. T. King

NEW BRUNSWICK CATHOLIC HEALTH
ASSOCIATION

George W. Martin
George W. Martin, President

LES RELIGIEUSES DE NOTRE-DAME
DU SACRE-COEUR

S. Bernice Gaudet
Sr. Bernice Gaudet

S. Adele Morin
Sr. Adele Morin

RELIGIOUS HOSPITALERS OF SAINT JOSEPH

Sister Anne Russell R.H.S.
Sr. Anne Russell

LA CONGREGATION DES FILLES DE
JESUS

S. Dora Bourgeois
Sr. Dora Bourgeois

S. Ernestine Boudreau
Sr. Ernestine Boudreau

Sister Rosemarie Kugel R.H.S.
Sr. Rosemarie Kugel

SISTERS OF CHARITY OF THE
IMMACULATE CONCEPTION

Sister Margaret Toner
Sr. Margaret Toner

Sister Sandra Barrett R.H.S.
Sr. Sandra Barrett

LES RELIGIEUSES HOSPITALIERES
DE SAINT-JOSEPH

Sr. Anne-Marie Savoie R.H.S.
Sr. Anne-Marie Savoie

Sr. Sarah Maillet R.H.S.
Sr. Sarah Maillet

APPENDIX C

LETTER OF UNDERSTANDING BETWEEN

PROVINCE OF NEW BRUNSWICK
and
NEW BRUNSWICK CATHOLIC HEALTH ASSOCIATION
LA CONGRÉGATION DES FILLES DE JÉSUS
SISTERS OF CHARITY OF THE IMMACULATE CONCEPTION
LES RELIGIEUSES DE NOTRE-DAME DU SACRÉ-CŒUR
RELIGIOUS HOSPITALIERS OF ST. JOSEPH
LES RELIGIEUSES HOSPITALIÈRES DE SAINT-JOSEPH

This document contains the substance of an agreement between the parties listed in relation to issues of concern to the Association and the Catholic Religious Orders as a result of the hospital system restructuring and rationalization plan initiated by the Province in March 1992.

All parties undertake to use their best efforts to implement the spirit and intent of these understandings through legislation and regulations, contracts and leases, and in any other manner necessary to achieve the objective of a resolution of their differences.

The "religious hospitals" referred to in this Letter of Understanding are those listed in Appendix "A".

- 1.* The mission statements that have been associated, or will be established, with respect to the delivery of services at the religious hospitals will be adhered to and this will be reflected in the Region Hospital Corporations' by-laws. Only services consistent with the above will be provided in the religious hospitals.

However, since the services to be available in each religious hospital will continue to be defined by the Province in the Hospital System Master Plan, as will the number and types of beds, the existing mission statements will be revised, as

required, to remove any references to specific bed numbers and services except as provided for in the Hospital Master Plan.

- * Section 47 of Regulation 92-84 under the Hospital Act will be amended to provide that the Minister "shall" require boards of trustees to enact by-laws respecting mission statements.

2. Any physical features/characteristics that reflect a religious hospital's association with a Religious Order will remain in place. The names of the religious hospitals will be retained.
3.
 - (a) Each Order will have an opportunity to provide input directly to the respective Region Board on the selection of the facility administrator in the following manner. The facility administrator of a religious hospital shall be appointed by the Region Board on the recommendation of an interview panel, 50% of the members of which will be appointed by the Advisory Committee and 50%, including the Region C.E.O., appointed by the Region Board.
 - (b) The job description of facility administrators of religious hospitals shall be basically the same for all religious hospitals; the region C.E.O.'s, to whom the facility administrators report, shall delegate to the facility administrators the responsibility of operating those hospitals on a day to day basis.
 - (c) The facility administrators of religious hospitals shall be involved in the selection and making recommendations for the appointment of directors and other staff who report directly to the facility administrator.
 - (d) The Provincial Government, through the Region Hospital Corporations, continues to be the employer of all hospital personnel.
4. The facility administrator, region and other staff, and also the medical practitioners who use the religious hospitals, will agree in writing to abide by the mission statement in effect from time to time in the religious hospitals in which they work.
- 5.* One of the members of each Region Board will be a nominee of the Order owning a religious hospital in that region, and this will be reflected in the Regulations and in the by-laws of the Region Hospital Corporations.

APPENDIX C

289

- 6.** (a) There shall be an Advisory Committee, established pursuant to provisions in the Hospital Act, for each religious hospital. An Advisory Committee shall consist of not more than 8 persons appointed by, and reporting to, the respective Orders. The Advisory Committee shall be responsible for the development and revision of the mission statement as it relates to the preservation of the character of each religious hospital. This mission statement shall not be in conflict with respective region service plan.
- * (b) An Advisory Committee shall have the role and responsibility of monitoring the performance of the facility administrator in the operation of the hospital as a religious hospital; an Advisory Committee may make recommendations, through the Region Boards, to require that the Regulations and by-laws relating to a religious hospital be observed.
- * (c) An Advisory Committee shall have access to the staff and relevant records of the religious hospital and Region Board in order to carry out its role as overseer of the mission.
- * (d) An Advisory Committee's role shall encompass the determination of the mission programs and services essential to maintain the character of the religious hospital.
- * (e) An Advisory Committee's role shall also encompass monitoring and requiring corrective measures in the subsequent application of the mission programs and services so established.
- * (f) Each Advisory Committee will be chaired by a nominee of the respective Order, who will have direct access to the region C.E.O., as required. An honorarium will be provided in regard to this function.
- * (g) The Region Hospital Corporations will cover the reasonable costs associated with the Advisory Committees within established government guidelines.
7. There will be leases governing the use of the religious hospitals by the Region Hospital Corporations that will run indefinitely. A two year notice of withdrawal by either party will be required.
8. The agreement implementing this Letter of Understanding remains in effect with respect to each religious hospital as long as the respective Order continues to own any portion of that hospital.

APPENDIX C

290

9. As long as the condition stated in paragraph 8 remains in effect, the Department of Health will provide annual grants to the Orders necessary to maintain the active institutional membership of the religious hospitals in the New Brunswick Catholic Health Association and the Catholic Health Association of Canada.
10. If an Order wishes to relinquish its financial interest and the Region Hospital Corporation wishes to continue using the facility, the aforementioned safeguards become null and void.
11. It is agreed that:
 - an independent and mutually acceptable determination of the level of ownership (equity) will be carried out by mutually acceptable professionals, with free access to all necessary documents,
 - any disagreement, which cannot be resolved, with respect to the process of determining the level of ownership shall result in the application of the arbitration provisions contained in section 32 of the Hospital Act, and
 - a Region Hospital Corporation, following consultation with the Advisory Committee, will have full authority to undertake any physical modifications required to enable the facility to carry out its assigned functions in an efficient, effective, quality manner, provided such modifications are in accordance with the provisions of a lease of the facility.
- 12.**The Province agrees to amend the Hospital Act to allow a body corporate, including those established and controlled by a religious denomination,
 - (a) to establish, operate and maintain a hospital facility in the Province; and
 - (b) to operate such facility in accord with the tenets and beliefs of that religious denomination.
13. The amendments will make clear the right of the Minister of Health and Community Services or the Lieutenant Governor in Council to establish the criteria, rules or standards for the operation of the facility. The power to establish such criteria, rules or standards will include the power to regulate aspects of the operation relating hospital care delivery, admission and discharge, record keeping, medical staff and committees, medical staff privileges, reporting requirements to the Minister, the right of inspection by the Minister or agent, and in general, other matters relating to hospital care delivery; the power will be limited to criteria, rules and standards consistent with those of general application to other hospital facilities.

14. The amendments will make clear that nothing in the amendments shall have the effect of jeopardising the authority of the province to enact legislation or to implement plans or programs directed to the control of physician human resource planning.
15. The rights contained in the amendments will not include the right to operate hospital facilities from hospital buildings presently owned by bodies corporate which have been prevented from operating hospital facilities pursuant to the provisions of Sections 2 to 9 inclusive of the Hospital Act, unless and until those buildings, or any separate section of those buildings, are no longer used as a hospital facility by the respective Region Hospital Corporation; in addition, this restriction shall not apply to adjacent lands or buildings not required for the operation of these hospital buildings.
16. Nothing in the amendments to the Hospital Act shall create, or imply, an obligation that facilities operated by bodies corporate established pursuant to those amendments are entitled to receive provincial government capital grants or operating grants.
17. The operation of hospital facilities by bodies corporate established pursuant to those amendments shall not jeopardise the ability of the province to provide effective, efficient quality care through the publicly funded hospital system.
18. The substance of this Letter of Understanding will be embodied in a detailed agreement intended to bind the Orders, the Minister of Health and Community Services, and the Region Hospital Corporations. The agreement, when completed, will include the leases of the religious hospitals to the Region Hospital Corporations.
19. The Regulations under the Hospital Act will be amended, in addition to section 47, to define the role and powers of an Advisory Committee, and to provide for the membership of a nominee of the Orders on each Region Board. The definition of the necessary Regulations amendments is assigned to the solicitors for the parties.

APPENDIX C

292

- * Items to be reflected in Regulations
- ** Items to be implemented by amendments to the Hospital Act

This Letter of Understanding signed on behalf of the parties as of April 21, 1993.

PROVINCE OF NEW BRUNSWICK AS
REPRESENTED BY THE MINISTER OF
HEALTH AND COMMUNITY SERVICES

Russell H.T. King
Honourable Russell H.T. King

NEW BRUNSWICK CATHOLIC HEALTH
ASSOCIATION

George Martin
George Martin, President

LA CONGREGATION DES FILLES DE JÉSUS

Sr. Dora Bourgeois
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Sr. Rosemarie Kugel
Sr. Rosemarie Kugel

LES RELIGIEUSES HOSPITALIÈRES DE
SAINT-JOSEPH

Sr. Anne-Marie Savoie
Sr. Anne-Marie Savoie

Sr. Sarah Maillet
Sr. Sarah Maillet

APPENDIX C

APPENDIX A

1. St. Joseph's Hospital, Saint John
2. L'Hôpital Stella-Maris-de-Kent, Ste-Anne-de-Kent
3. The Sisters of ~~St. Joseph~~^{St.} of the Hotel Dieu, Chatham, N.B.
4. L'Hôpital de l'Enfant-Jésus, Caraquet
5. L'Hôpital St.-Joseph, Dalhousie
6. L'Hôtel-Dieu de St.-Joseph, St.-Quentin
7. Hotel Dieu of Saint Joseph, Perth-Andover

APPENDIX D

BILL 82

AN ACT TO AMEND THE HOSPITAL ACT

2nd Session, 52nd Legislature
New Brunswick
42 Elizabeth II, 1993

2^e session, 52^e législature
Nouveau-Brunswick
42 Elizabeth II, 1993

BILL

82

AN ACT TO AMEND THE
HOSPITAL ACT

PROJET DE LOI

LOI MODIFIANT LA
LOI HOSPITALIÈRE

HON. RUSSELL H.T. KING

L'HON. RUSSELL H.T. KING

EXPLANATORY NOTES

Section 1

The existing provision is: "patient" means a person who receives hospital services from a hospital corporation.

Section 2

The existing provision is:

16(1) No person other than a hospital corporation shall establish, operate or maintain a hospital facility in the Province.

Section 3

The existing provision is:

26(7) If a hospital facility not owned by the Province is destroyed or significantly damaged, it shall not be replaced or repaired except as a hospital facility totally owned by the Province.

Section 4

Section 30 of the *Hospital Act* deals with the disposition of hospital facilities and of the property associated with them when the facilities cease to be used as hospital facilities.

Section 5

Provisions are added in relation to hospital facilities established, operated or maintained by persons other than hospital corporations.

Section 6

Inspection provisions are added.

Section 7

A provision is added to deal with continuing offences.

Section 8

(a)(i) to (a)(iii) Regulation-making powers are added or modified to accommodate hospital facilities established, operated or maintained by persons other than hospital corporations.

(a)(iv) A reference to inspection is removed from paragraph 35(1)(p) of the *Hospital Act*.

(a)(v) A regulation-making power in relation to inspections is added.

NOTES EXPLICATIVES

Article 1

La disposition actuelle se lit comme suit: «malade» désigne une personne qui reçoit des services hospitaliers d'une corporation hospitalière;

Article 2

La disposition actuelle se lit comme suit:

16(1) Nulle personne autre qu'une corporation hospitalière ne peut établir, exploiter ou maintenir un établissement hospitalier dans la province.

Article 3

La disposition actuelle se lit comme suit:

26(7) Un établissement hospitalier n'appartenant pas à la province qui est détruit ou a subi des dommages substantiels ne doit pas être remplacé ou réparé si ce n'est comme établissement hospitalier qui est la propriété entière de la province.

Article 4

L'article 30 de la *Loi hospitalière* concerne la manière de disposer des établissements hospitaliers et des biens qui y sont reliés lorsque les établissements cessent d'être utilisés comme établissements hospitaliers.

Article 5

Des dispositions sont ajoutées relativement aux établissements hospitaliers établis, exploités ou maintenus par des personnes autres que des corporations hospitalières.

Article 6

Des dispositions relatives à l'inspection sont ajoutées.

Article 7

Une disposition est ajoutée concernant les infractions qui se continuent.

Article 8

a)(i) à a)(iii) Des dispositions habilitantes du pouvoir réglementaire sont ajoutées ou modifiées pour s'adapter aux établissements hospitaliers établis, exploités ou maintenus par des personnes autres que les corporations hospitalières.

a)(iv) Un renvoi à l'inspection est supprimé à l'alinéa 35(1)p) de la *Loi hospitalière*.

a)(v) Une disposition habilitante du pouvoir réglementaire relativement aux inspections est ajoutée.

APPENDIX D

1993

**An Act to Amend the
Hospital Act**

**Loi modifiant la
Loi hospitalière**

Her Majesty, by and with the advice and consent of the Legislative Assembly of New Brunswick, enacts as follows:

1 *Section 1 of the Hospital Act, chapter H-6.1 of the Acts of New Brunswick, 1992, is amended by repealing the definition "patient" and substituting the following:*

"patient" means a person who receives hospital services from a hospital corporation or from a person who holds a licence issued under section 32.1, as the case may be.

2 *Subsection 16(1) of the Act is repealed and the following is substituted:*

16(1) Subject to section 32.1, no person other than a hospital corporation shall establish, operate or maintain a hospital facility in the Province.

3 *Subsection 26(7) of the Act is repealed and the following is substituted:*

26(7) If a hospital facility that is operated and maintained by a hospital corporation but that is not owned by the Province is destroyed or significantly damaged, it shall not be replaced or re-

Sa Majesté, sur l'avis et du consentement de l'Assemblée législative du Nouveau-Brunswick, décrète:

1 *L'article 1 de la Loi hospitalière, chapitre H-6.1 des Lois du Nouveau-Brunswick de 1992, est modifié par l'abrogation de la définition «malade» et son remplacement par ce qui suit:*

«malade» désigne une personne qui reçoit des services hospitaliers d'une corporation hospitalière ou d'une personne qui détient une licence délivrée en vertu de l'article 32.1, selon le cas;

2 *Le paragraphe 16(1) de la Loi est abrogé et remplacé par ce qui suit:*

16(1) Sous réserve de l'article 32.1, nulle personne autre qu'une corporation hospitalière ne peut établir, exploiter ou maintenir un établissement hospitalier dans la province.

3 *Le paragraphe 26(7) de la Loi est abrogé et remplacé par ce qui suit:*

26(7) Si un établissement hospitalier qui est exploité et maintenu par une corporation hospitalière mais qui n'appartient pas à la province est détruit ou a subi des dommages substantiels, il ne

paired except as a hospital facility totally owned by the Province.

4 Section 30 of the Act is amended by adding after subsection (5) the following:

30(5.1) This section does not apply to hospital facilities that are established, operated and maintained by persons who hold licences issued under section 32.1.

5 The Act is amended by adding after section 32 the following:

32.1(1) A person other than a hospital corporation may establish, operate or maintain a hospital facility in the Province if the Minister has issued to the person a licence authorizing the person to establish, operate or maintain a hospital facility.

32.1(2) The Minister shall issue a licence to a person other than a hospital corporation authorizing the person to establish, operate or maintain a hospital facility in the Province if the person

(a) has paid the fee fixed by or in accordance with the regulations for payment on an application for a licence;

(b) has provided all of the information required by or in accordance with the regulations, and

(c) has met all of the terms and conditions established by or in accordance with the regulations.

32.1(3) A licence issued under this section is subject

(a) to the terms and conditions that are specified by or in accordance with the regulations, and

doit pas être remplacé ou réparé si ce n'est comme établissement hospitalier qui est la propriété entière de la province.

4 L'article 30 de la Loi est modifié par l'adjonction après le paragraphe (5) de ce qui suit:

30(5.1) Le présent article ne s'applique pas aux établissements hospitaliers qui sont établis, exploités et maintenus par des personnes qui détiennent des licences délivrées en vertu de l'article 32.1

5 La Loi est modifiée par l'adjonction après l'article 32 de ce qui suit:

32.1(1) Une personne autre qu'une corporation hospitalière peut établir, exploiter ou maintenir un établissement hospitalier dans la province si le Ministre a délivré à la personne une licence autorisant la personne à établir, exploiter ou maintenir un établissement hospitalier.

32.1(2) Le Ministre doit délivrer une licence à une personne autre qu'une corporation hospitalière autorisant la personne à établir, exploiter ou maintenir un établissement hospitalier dans la province si la personne

a) a versé le droit fixé par les règlements ou conformément à ceux-ci pour paiement lors d'une demande de licence,

b) a fourni tous les renseignements requis par les règlements ou conformément à ceux-ci, et

c) a satisfait à toutes les modalités et conditions établies par les règlements ou conformément à ceux-ci.

32.1(3) Une licence délivrée en vertu du présent article est assujettie

a) aux modalités et conditions qui sont précisées par les règlements ou conformément à ceux-ci, et

(b) to such additional terms and conditions as the Minister considers appropriate and specifies in the licence.

32.1(4) A licence issued under this section is valid for the period of time specified in it.

32.1(5) The Minister shall renew a licence issued under this section if

(a) the fee fixed by or in accordance with the regulations for payment on an application for a renewal of a licence has been paid;

(b) all of the information required by or in accordance with the regulations has been provided, and

(c) all of the terms and conditions established by or in accordance with the regulations have been met.

32.1(6) On renewing a licence under this section, the Minister may modify and add to the terms and conditions referred to in paragraph (3)(b).

32.1(7) A licence issued under this section is not transferable.

32.2 If a patient who is an indigent person, or the dependant of an indigent person, dies in a hospital facility operated or maintained by a person who holds a licence issued under section 32.1, the Minister of Income Assistance shall, in accordance with the regulations, pay to the person who holds the licence any expenses of burial incurred by the person who holds the licence.

32.3(1) A person who holds a licence issued under section 32.1 shall not establish, operate or maintain a hospital facility in the Province contrary to a term or condition to which the licence is subject.

32.3(2) A person who holds a licence issued under section 32.1 shall not engage in any program

b) aux modalités et conditions additionnelles que le Ministre estime appropriées et qu'il précise dans la licence.

32.1(4) Une licence délivrée en vertu du présent article est valide pour la période qui y est précisée.

32.1(5) Le Ministre doit renouveler une licence délivrée en vertu du présent article si

a) le droit fixé par les règlements ou conformément à ceux-ci pour paiement lors d'une demande de renouvellement de licence, a été versé,

b) tous les renseignements requis par les règlements ou conformément à ceux-ci ont été fournis, et

c) toutes les modalités et conditions établies par les règlements ou conformément à ceux-ci ont été satisfaites.

32.1(6) Lors du renouvellement d'une licence en vertu du présent article, le Ministre peut modifier les modalités et conditions visées à l'alinéa (3)b) et y faire des additions.

32.1(7) Une licence délivrée en vertu du présent article n'est pas transférable.

32.2 Si un malade qui est un indigent ou une personne à charge d'un indigent décède dans un établissement hospitalier exploité ou maintenu par une personne qui détient une licence délivrée en vertu de l'article 32.1, le ministre de l'Aide au revenu doit, conformément aux règlements, verser à la personne qui détient la licence, les frais que celle-ci supporte pour l'enterrement.

32.3(1) Une personne qui détient une licence délivrée en vertu de l'article 32.1 ne peut établir, exploiter ou maintenir un établissement hospitalier dans la province contrairement à une modalité ou condition à laquelle la licence est assujettie.

32.3(2) Une personne qui détient une licence délivrée en vertu de l'article 32.1 ne peut réaliser un

to train persons in the medical and allied professions.

32.3(3) Despite subsection (2), a person who holds a licence issued under section 32.1 may engage in education programs designed to acquaint staff, servants and employees with new developments in their respective areas of expertise.

32.4(1) The Minister may, in accordance with the regulations, suspend or revoke a licence issued under section 32.1.

32.4(2) A patient is not liable for the cost of hospital services delivered at a hospital facility in relation to which the licence issued under section 32.1 has been suspended or revoked.

32.4(3) If a licence issued under section 32.1 is suspended or revoked, the person to whom the licence was issued shall discontinue admission of patients as of the date of the suspension or revocation and shall, having considered the health and safety of the patients, discharge existing patients at the earliest possible time.

32.4(4) The Minister may, in accordance with the regulations, and on payment of the fee fixed by or in accordance with the regulations for payment on the reinstatement of a licence, reinstate a licence suspended under this section.

32.4(5) On reinstating a licence under this section, the Minister may modify and add to the terms and conditions referred to in paragraph 32.1(3)(b).

32.5(1) No action shall be brought for damages for injury as a result of any negligence in the admission of a patient to a hospital facility established, operated or maintained by a person who holds a licence issued under section 32.1, the delivery of hospital services to a patient at such a hospital facility or the discharge of a patient from such a hospital facility except within two years af-

programme de formation de personnes aux professions médicales et paramédicales.

32.3(3) Nonobstant le paragraphe (2), une personne qui détient une licence délivrée en vertu de l'article 32.1 peut s'engager dans des programmes de formation, destinés à familiariser les membres du personnel, les préposés et les employés à l'évolution respective de leurs spécialités.

32.4(1) Le Ministre peut, conformément aux règlements, suspendre ou révoquer une licence délivrée en vertu de l'article 32.1.

32.4(2) Un malade n'est pas responsable des frais des services hospitaliers dispensés dans un établissement hospitalier relativement auquel la licence délivrée en vertu de l'article 32.1 a été suspendue ou révoquée.

32.4(3) Si une licence délivrée en vertu de l'article 32.1 est suspendue ou révoquée, la personne à qui la licence a été délivrée doit cesser d'admettre des malades à la date de la suspension ou de la révocation et doit, compte tenu de la santé et de la sécurité des malades, faire sortir les malades qui sont déjà dans l'établissement aussitôt que possible.

32.4(4) Le Ministre peut, conformément aux règlements, et sur paiement du droit fixe par les règlements ou conformément à ceux-ci pour paiement lors du rétablissement d'une licence, rétablir une licence suspendue en vertu du présent article.

32.4(5) Lors du rétablissement d'une licence en vertu du présent article, le Ministre peut modifier les modalités et conditions visées à l'alinéa 32.1(3)b) et y faire des additions.

32.5(1) L'action en dommages-intérêts à raison d'un préjudice causé par une négligence dans l'admission d'un malade dans un établissement hospitalier établi, exploité ou maintenu par une personne qui détient une licence délivrée en vertu de l'article 32.1 à raison de la dispensation des services hospitaliers à un malade dans cet établissement hospitalier ou à raison de la sortie d'un ma-

ter the patient is discharged or ceases to receive hospital services, or within one year after the person bringing the action knew or ought to have known the facts on which the person alleges negligence, whichever is later.

32.5(2) If a person entitled to bring an action is at the time the cause of action arises a minor, mentally incompetent or of unsound mind, the limitation period referred to in subsection (1) does not begin to run until the person reaches the age of majority or becomes mentally competent or of sound mind, as the case may be.

32.6(1) A person who holds a licence issued under section 32.1 shall maintain a record for each patient in accordance with the regulations.

32.6(2) A person who holds a licence issued under section 32.1 shall maintain such additional records and shall make such reports and returns as are required by the regulations.

32.7(1) The fiscal year of a person who holds a licence issued under section 32.1 begins on the first day of April in one year and ends on the thirty-first day of March in the next year.

32.7(2) A person who holds a licence issued under section 32.1 shall

(a) maintain books, accounts and accounting systems and perform audits in accordance with the regulations,

(b) submit an annual report, including a financial statement in such form and containing such information as may be required by the Minister and an auditor's report on the financial statement, to the Minister on or before the thirty-first day of July in each year for the preceding fiscal year, and

lade de cet établissement hospitalier ne peut être intentée que dans les deux ans qui suivent la sortie du malade ou la cessation de la réception des services hospitaliers, ou bien dans l'année qui suit la date où la personne qui intente l'action a connu ou aurait dû connaître les faits qu'elle dénonce comme négligence, selon la dernière éventualité.

32.5(2) Lorsque la personne qui a droit d'intenter une action est, à la date où naît la cause d'action, mineure, incapable mentale ou privée de raison, le délai de prescription visé au paragraphe (1) ne commence à courir que lorsque cette personne atteint l'âge de la majorité ou devient capable mentale ou saine d'esprit, selon le cas.

32.6(1) Une personne qui détient une licence délivrée en vertu de l'article 32.1 doit tenir un dossier pour chaque malade conformément aux règlements.

32.6(2) Une personne qui détient une licence délivrée en vertu de l'article 32.1 doit tenir des dossiers supplémentaires et doit rédiger les rapports et les déclarations qui sont requis par les règlements.

32.7(1) L'année financière d'une personne qui détient une licence délivrée en vertu de l'article 32.1 commence le 1^{er} avril d'une année et prend fin le 31 mars de l'année suivante.

32.7(2) Une personne qui détient une licence délivrée en vertu de l'article 32.1 doit

a) tenir des registres comptables, des livres de comptes et des systèmes de comptabilité et exécuter des vérifications conformément aux règlements,

b) soumettre un rapport annuel, y compris un état financier selon la forme et contenant les renseignements qui peuvent être requis par le Ministre et un rapport du vérificateur sur les états financiers, au Ministre, le 31 juillet de chaque année ou avant cette date, pour l'année financière précédente, et

(c) conduct such additional analysis in relation to any aspect of the operations of the person, or of a hospital facility operated or maintained by the person, as may be required by the Minister, and attach to the annual report the results of the analysis and such other information in relation to it as may be required by the Minister.

c) procéder à une analyse supplémentaire concernant tout aspect des activités de la personne, ou d'un établissement hospitalier exploité ou maintenu par la personne, selon ce que le Ministre peut exiger, et annexer au rapport annuel les résultats de l'analyse et d'autres renseignements y afférents que le Ministre peut exiger.

32.8 A person who holds a licence issued under section 32.1 shall maintain adequate insurance coverage for the protection of all patients, visitors, staff and other persons who are, by invitation, at hospital facilities established, operated or maintained by the person.

32.8 Une personne qui détient une licence délivrée en vertu de l'article 32.1 doit garder en vigueur une assurance convenable pour protéger les malades, les visiteurs, le personnel et les autres personnes qui se trouvent sur invitation dans l'établissement hospitalier établi, exploité ou maintenu par la personne.

6 *The Act is amended by adding before section 33 the following:*

6 *La Loi est modifiée par l'adjonction avant l'article 33 de ce qui suit:*

32.9(1) The Minister may appoint persons as inspectors for the purposes of inspecting hospital facilities.

32.9(1) Le Ministre peut nommer des personnes comme inspecteurs aux fins d'inspecter les établissements hospitaliers.

32.9(2) The Minister shall issue to each inspector a certificate of the inspector's appointment and every inspector shall produce her or his certificate of appointment on request.

32.9(2) Le Ministre doit délivrer à chaque inspecteur un certificat de nomination de l'inspecteur et chaque inspecteur doit exhiber son certificat de nomination sur demande.

32.9(3) An inspector may at any reasonable time enter a hospital facility to inspect and inquire with respect to the premises, physical plant, equipment, furnishings, management, operation and general administration of a hospital facility to ensure that the provisions of this Act and the regulations are being complied with.

32.9(3) Un inspecteur peut en tout temps raisonnable entrer dans un établissement hospitalier pour mener inspection et enquête concernant les locaux, les bâtiments, le matériel, l'ameublement, l'administration, le fonctionnement et l'administration en général de l'établissement hospitalier pour y vérifier si les dispositions de la présente loi et des règlements sont observées.

32.9(4) Before or after attempting to enter a hospital facility under subsection (3), an inspector may apply for an entry warrant in accordance with the *Entry Warrants Act*.

32.9(4) Avant de tenter d'entrer ou après avoir tenté d'entrer dans un établissement hospitalier en vertu du paragraphe (3), un inspecteur peut demander un mandat d'entrée conformément à la *Loi sur les mandats d'entrée*.

32.9(5) On an inspection under this section, the inspector

32.9(5) Lors d'une inspection faite en vertu du présent article, l'inspecteur

(a) is entitled to free access to all documents, books, accounts, correspondence and records, including patient, medical, drug and financial records, that are relevant for the purposes of the inspection,

(b) may, upon giving a receipt, remove any material referred to in paragraph (a) that relates to the purposes of the inspection for the purpose of making copies of the material, if the copying is carried out with reasonable dispatch and the material is promptly returned after copying,

(c) may require a chief executive officer at a hospital facility

(i) to furnish any information possessed or controlled by the chief executive officer, and

(ii) to make returns, reports or statements in writing relating to the hospital facility, and

(d) may do such additional things as may be authorized by or in accordance with the regulations.

32.9(6) No person shall obstruct an inspector who is carrying out or attempting to carry out an inspection or inquiry under this section, or withhold or destroy, conceal or refuse to furnish any information or thing required by the inspector for the purposes of the inspection.

32.9(7) A copy made as provided in subsection (5) and purporting to be certified by an inspector is admissible in evidence in any action, proceeding or prosecution as *prima facie* proof of the original without proof of the signature or official character of the person appearing to have signed the certificate.

a) a libre accès à tous les documents, à tous les registres, à tous les livres de comptes, à toute la correspondance et à tous les dossiers, y compris les dossiers des malades, les dossiers médicaux, les dossiers des médicaments et les dossiers financiers pertinents aux fins de l'inspection,

b) peut, sur remise d'un reçu, déplacer tout document visé à l'alinéa a) pertinent aux fins de l'inspection afin d'en tirer une copie, si cette opération est exécutée avec une diligence raisonnable et si le document en question est remis promptement à la personne faisant l'objet de l'inspection, et

c) peut obliger le directeur général d'un établissement hospitalier à

(i) soumettre tous renseignements en sa possession ou sous son contrôle, et

(ii) rédiger par écrit des relevés, rapports ou déclarations concernant l'établissement hospitalier, et

d) peut faire toutes choses additionnelles autorisées par les règlements ou conformément à ceux-ci.

32.9(6) Nulle personne ne doit gêner les activités de l'inspecteur qui fait une inspection ou qui tente de faire une inspection ou une enquête en vertu du présent article, ni retenir, détruire, dissimuler ou refuser de fournir tout renseignement ou toute chose exigés par l'inspecteur pour les fins de l'inspection.

32.9(7) Toute copie faite conformément au paragraphe (5) et paraissant être certifiée conforme par l'inspecteur est admissible en preuve lors de toute action, procédure ou poursuite comme preuve *prima facie* de l'original, sans qu'il soit besoin de prouver l'authenticité de la signature ou le titre officiel de la personne paraissant avoir signé le certificat.

7 Section 33 of the Act is amended by adding after subsection (3) the following:

33(4) If an offence under this Act continues for more than one day

(a) the minimum fine that may be imposed is the minimum fine set by the Provincial Offences Procedure Act multiplied by the number of days during which the offence continues, and

(b) the maximum fine that may be imposed is the maximum fine set by the Provincial Offences Procedure Act multiplied by the number of days during which the offence continues.

8 Section 35 of the Act is amended

(a) in subsection (1)

(i) by adding after paragraph (j) the following:

(j.1) respecting applications for licences under section 32.1, including the information to be provided by applicants and the terms and conditions to be met by applicants;

(j.2) respecting the terms and conditions to which licences issued under section 32.1 are subject;

(j.3) respecting the renewal of licences issued under section 32.1, including applications for the renewal of such licences, the information to be provided by applicants and the terms and conditions to be met by applicants;

(j.4) respecting the suspension and revocation of licences issued under section 32.1;

(j.5) respecting the reinstatement of suspended licences;

7 L'article 33 de la Loi est modifié par l'adjonction après le paragraphe (3) de ce qui suit:

33(4) Si une infraction en vertu de la présente loi se continue pendant plus d'un jour

a) l'amende minimale qui peut être imposée est l'amende minimale établie à la Loi sur la procédure applicable aux infractions provinciales multipliée par le nombre de jours pendant lesquels l'infraction se continue, et

b) l'amende maximale qui peut être imposée est l'amende maximale établie par la Loi sur la procédure applicable aux infractions provinciales multipliée par le nombre de jours pendant lesquels l'infraction se continue.

8 L'article 35 de la Loi est modifié

a) au paragraphe (1)

(i) par l'adjonction après l'alinéa j) de ce qui suit:

j.1) concernant les demandes de licences en vertu de l'article 32.1, y compris les renseignements à fournir par les requérants et les modalités et conditions auxquelles les requérants doivent satisfaire;

j.2) concernant les modalités et conditions auxquelles les licences délivrées en vertu de l'article 32.1 sont assujetties;

j.3) concernant le renouvellement des licences délivrées en vertu de l'article 32.1, y compris les demandes de renouvellement de ces licences, les renseignements à fournir par les requérants et les modalités et conditions auxquelles les requérants doivent satisfaire;

j.4) concernant la suspension et la révocation des licences délivrées en vertu de l'article 32.1;

j.5) concernant le rétablissement des licences suspendues;

(j.6) respecting the fees payable on an application for a licence or a renewal of a licence under section 32.1, and making the fees non-refundable;

(j.7) respecting the fees payable on the reinstatement of a licence under section 32.4;

(j.8) respecting the appointment, powers, privileges and duties of officers, chief executive officers, medical staff and other staff and employees at hospital facilities established, operated or maintained by persons who hold licences issued under section 32.1;

(ii) by repealing paragraph (n) and substituting the following:

(n) respecting the classification and grading of hospital corporations and of hospital facilities established, operated or maintained by hospital corporations;

(iii) by adding after paragraph (n) the following:

(n.1) respecting the classification and grading of persons other than hospital corporations who establish, operate or maintain hospital facilities, and of the hospital facilities established, operated or maintained by such persons;

(iv) by repealing paragraph (p) and substituting the following:

(p) respecting the control, government, management, conduct, operation and use of hospital facilities;

(v) by adding after paragraph (p) the following:

(p.1) respecting the inspection of hospital facilities, including additional powers and duties of inspectors;

j.6) concernant les droits à verser lors d'une demande de licence ou de renouvellement d'une licence en vertu de l'article 32.1, et prévoyant que les droits sont non-remboursables;

j.7) concernant les droits à verser lors du rétablissement d'une licence en vertu de l'article 32.4;

j.8) concernant la nomination, les pouvoirs, les privilèges et les fonctions des dirigeants, des directeurs généraux, des membres du personnel médical et autres membres du personnel et employés des établissements hospitaliers établis, exploités ou maintenus par les personnes qui détiennent des licences délivrées en vertu de l'article 32.1;

(ii) par l'abrogation de l'alinéa n) et son remplacement par ce qui suit:

n) concernant la classification et la catégorie des corporations hospitalières et des établissements hospitaliers établis, exploités ou maintenus par les corporations hospitalières;

(iii) par l'adjonction après l'alinéa n) de ce qui suit:

n.1) concernant la classification et la catégorie des personnes autres que les corporations hospitalières qui établissent, exploitent ou maintiennent des établissements hospitaliers, et des établissements hospitaliers établis, exploités ou maintenus par ces personnes;

(iv) par l'abrogation de l'alinéa p) et son remplacement par ce qui suit:

p) concernant le contrôle, la direction, la gestion, la marche, l'exploitation et l'usage des établissements hospitaliers;

(v) par l'adjonction après l'alinéa p) de ce qui suit:

p.1) concernant l'inspection des établissements hospitaliers, y compris les pouvoirs additionnels et les fonctions des inspecteurs;

APPENDIX D

(vi) by adding after paragraph (q) the following:

(q.1) respecting payments to be made by the Minister of Income Assistance for expenses of burial in relation to indigent persons, or the dependants of indigent persons, who die in hospital facilities;

(vii) by adding after paragraph (t) the following:

(t.1) respecting additional records to be maintained, and reports and returns to be made by persons who hold licences issued under section 32.1;

(viii) by adding after paragraph (u) the following:

(u.1) respecting books, accounts and accounting systems to be maintained and the audits to be performed by persons who hold licences issued under section 32.1;

(b) by repealing subsection (2) and substituting the following:

35(2) The Lieutenant-Governor in Council may declare, for such time or times as the Lieutenant-Governor in Council considers appropriate, all or any of the regulations to be in force with respect only

(a) to any one or more hospital corporations or hospital facilities established, operated or maintained by hospital corporations, or

(b) to any one or more classes of hospital corporations or hospital facilities established, operated or maintained by hospital corporations.

(vi) par l'adjonction après l'alinéa q) de ce qui suit:

q.1) concernant les paiements qui doivent être effectués par le Ministre de l'Aide au revenu pour les dépenses d'enterrement relativement aux personnes indigentes, ou aux personnes à charge de personnes indigentes, qui décèdent dans des établissements hospitaliers;

(vii) par l'adjonction après l'alinéa t) de ce qui suit:

t.1) concernant les registres supplémentaires à tenir et les rapports et relevés que les personnes qui détiennent des licences délivrées en vertu de l'article 32.1 doivent effectuer;

(viii) par l'adjonction après l'alinéa u) de ce qui suit:

u.1) concernant les registres, livres de comptes et les systèmes de comptabilité à tenir et les vérifications à effectuer par les personnes qui détiennent des licences délivrées en vertu de l'article 32.1;

b) par l'abrogation du paragraphe (2) et son remplacement par ce qui suit:

35(2) Le lieutenant-gouverneur en conseil peut déclarer, pour la période ou les périodes qu'il estime appropriées, que tous les règlements ou l'un d'entre eux ne sont en vigueur qu'à l'égard seulement

a) d'une ou de plusieurs corporations hospitalières ou d'un ou de plusieurs établissements hospitaliers établis, exploités ou maintenus par les corporations hospitalières,

b) d'une ou de plusieurs catégories de corporations hospitalières ou d'établissements hospitaliers établis, exploités ou maintenus par des corporations hospitalières.

APPENDIX D

(c) by adding after subsection (2) the following:

35(3) Regulations made under subsection (1) in relation to hospital facilities may differ for hospital facilities established, operated or maintained by hospital corporations and hospital facilities established, operated or maintained by persons other than hospital corporations.

9 Schedule A of the Act is amended

(a) by adding after

27(1) C

the following:

32.3(1)	E
32.3(2)	E
32.4(3)	E
32.6(1)	C
32.6(2)	C
32.7(2)	C
32.8	C

(b) by adding before

33(1) B

the following:

32.9(6) F

10 Sections 1 to 9 of this Act, or any provision of those sections, come into force on a day or days to be fixed by proclamation.

c) par l'adjonction après le paragraphe (2) de ce qui suit:

35(3) Les règlements établis en vertu du paragraphe (1) relativement aux établissements hospitaliers peuvent différer pour les établissements hospitaliers établis, exploités ou maintenus par les corporations hospitalières et les établissements hospitaliers établis, exploités ou maintenus par des personnes autres que les corporations hospitalières.

9 L'Annexe A de la Loi est modifiée

a) par l'adjonction après

27(1) C

de ce qui suit:

32.3(1)	E
32.3(2)	E
32.4(3)	E
32.6(1)	C
32.6(2)	C
32.7(2)	C
32.8	C

b) par l'adjonction avant

33(1) B

de ce qui suit:

32.9(6) F

10 Les articles 1 à 9 de la présente loi ou l'une quelconque des dispositions de ces articles, entrent en vigueur à la date ou aux dates fixées par proclamation.

APPENDIX D

(e)(vi) A regulation-making power is added in relation to the payment of expenses for the burial of indigent persons and their dependants.

(e)(vii) and (viii) Regulation-making powers are added in relation to hospital facilities established, operated or maintained by persons other than hospital corporations.

(b) Subsection 35(2) of the *Hospital Act* is amended to apply only to hospital corporations and to hospital facilities established, operated or maintained by hospital corporations.

(c) An authority is added to allow the making of regulations that differ for hospital facilities established, operated or maintained by hospital corporations and those established, operated or maintained by persons other than hospital corporations.

Section 9

Certain violations of the Act are established as offences and the offences are categorized for the purposes of the level of penalty.

Section 10

Commencement Provision.

e)(vi) Une disposition habilitante du pouvoir réglementaire est ajoutée relativement au paiement des dépenses d'enterrement des personnes indigentes et de leurs personnes à charge.

e)(vii) et (viii) Des dispositions habilitantes du pouvoir réglementaire sont ajoutées relativement aux établissements hospitaliers établis, exploités ou maintenus par des personnes autres que les corporations hospitalières.

b) Le paragraphe 35(2) de la *Loi hospitalière*, est modifié pour s'appliquer seulement aux corporations hospitalières et aux établissements hospitaliers établis, exploités ou maintenus par des corporations hospitalières.

c) Un pouvoir est ajouté pour permettre l'établissement de règlements qui diffèrent pour les établissements hospitaliers établis, exploités ou maintenus par des corporations hospitalières et ceux qui sont établis, exploités ou maintenus par des personnes autres que des corporations hospitalières.

Article 9

Certaines violations de la Loi sont établies comme infractions et les infractions sont classifiées aux fins de l'échelon de la pénalité.

Article 10

Entrée en vigueur.

APPENDIX E

BILL 83

AN ACT TO AMEND THE HOSPITAL ACT

2nd Session, 52nd Legislature
New Brunswick
42 Elizabeth II, 1993

2^e session, 52^e législature
Nouveau-Brunswick
42 Elizabeth II, 1993

BILL #83

**AN ACT TO AMEND THE
HOSPITAL ACT**

PROJET DE LOI

**LOI MODIFIANT LA
LOI HOSPITALIÈRE**

HON. RUSSELL H.T. KING

L'HON. RUSSELL H.T. KING

APPENDIX E

EXPLANATORY NOTES

Section 1

Provisions are added in relation to advisory committees for hospital facilities owned in whole or in part by religious orders.

Section 2

The existing provision is:

34(6) A designation made, a parameter established, a direction issued or an approval given, suspended or revoked by the Minister under this Act or the regulations is not a regulation within the meaning of the *Regulation Act*.

Section 3

(a) Regulation-making powers are added in relation to advisory committees.

(b) The existing provision is:

35(1) The Lieutenant-Governor in Council may make regulations

(x) authorizing the Minister to require the board of trustees of a hospital corporation to include in the by-laws of the hospital corporation provisions specified by the Minister to ensure the preservation in a hospital facility owned in whole or in part by a religious order of the philosophy, values and mission that been associated with the delivery of hospital services in that hospital facility;

Section 4

Commencement provision.

NOTES EXPLICATIVES

Article 1

Des dispositions sont ajoutées relativement aux comités consultatifs pour les établissements hospitaliers appartenant en tout ou en partie aux communautés religieuses.

Article 2

La disposition actuelle se lit comme suit:

34(6) Une désignation qui est faite, un paramètre qui est établi, une directive qui est délivrée ou une approbation qui est donnée, suspendue ou révoquée par le Ministre en vertu de la présente loi ou des règlements ne constitue pas un règlement au sens de la *Loi sur les règlements*.

Article 3

a) Des dispositions habilitantes du pouvoir réglementaire sont ajoutées relativement aux comités consultatifs.

b) La disposition actuelle se lit comme suit:

35(1) Le lieutenant-gouverneur en conseil peut établir des règlements

x) autorisant le Ministre à exiger du conseil de fiduciaires d'une corporation hospitalière l'inclusion dans les règlements administratifs de la corporation hospitalière de dispositions précisées par le Ministre pour assurer la préservation dans un établissement hospitalier appartenant en tout ou en partie à une communauté religieuse, de la philosophie, des valeurs et de la mission qui ont été associées à la dispensation des services hospitaliers dans cet établissement hospitalier;

Article 4

Entrée en vigueur.

1993

**An Act to Amend the
Hospital Act**

**Loi modifiant la
Loi hospitalière**

Her Majesty, by and with the advice and consent of the Legislative Assembly of New Brunswick, enacts as follows:

Sa Majesté, sur l'avis et du consentement de l'Assemblée législative du Nouveau-Brunswick, décrète:

1 *The Hospital Act, chapter H-6.1 of the Acts of New Brunswick, 1992, is amended by adding after section 15 the following:*

1 *La Loi hospitalière, chapitre H-6.1 des Lois du Nouveau-Brunswick de 1992, est modifiée par l'adjonction après l'article 15 de ce qui suit:*

15.1(1) There shall be an advisory committee for each hospital facility that is owned in whole or in part by a religious order and that is operated by a hospital corporation.

15.1(1) Est établi un comité consultatif pour chaque établissement hospitalier appartenant en tout ou en partie à une communauté religieuse et qui est exploité par une corporation hospitalière.

15.1(2) The members of an advisory committee referred to in subsection (1) shall be appointed by and report to the religious order that owns the hospital facility in whole or in part.

15.1(2) Les membres d'un comité consultatif prévu au paragraphe (1) sont nommés par la communauté religieuse à qui appartient en tout ou en partie l'établissement hospitalier et relèvent de cette communauté religieuse.

15.1(3) The purpose of an advisory committee is to ensure the preservation of the religious philosophy, values and mission associated with the hospital facility.

15.1(3) Le but d'un comité consultatif est d'assurer la préservation de la philosophie, des valeurs et des objectifs généraux à caractère religieux associés à l'établissement hospitalier.

15.1(4) An advisory committee may

15.1(4) Un comité consultatif peut

(a) prescribe for the hospital facility a statement respecting the philosophy, values and mis-

a) prescrire pour l'établissement hospitalier une déclaration concernant la philosophie, les

APPENDIX E

sion to be associated with the delivery of hospital services at the hospital facility,

(b) determine the mission programs and services essential to fulfil the mission set out in the statement prescribed under paragraph (a),

(c) monitor compliance with the statement prescribed under paragraph (a) and the mission programs and services determined under paragraph (b), and

(d) do such additional things as are prescribed by regulation.

15.1(5) The philosophy, values and mission set out in a statement prescribed under subsection (4) and the mission programs and services determined under subsection (4) shall not conflict with the parameters established and the directions issued by the Minister in relation to the planning, organization, management and delivery of hospital services by hospital corporations.

2 Subsection 34(6) of the Act is repealed and the following is substituted:

34(6) A designation made, a parameter or guideline established, a direction issued, a provision specified or an approval given, suspended or revoked by the Minister under this Act or the regulations is not a regulation within the meaning of the *Regulations Act*.

3 Subsection 35(1) of the Act is amended

(a) by adding after paragraph (i) the following:

(i.1) respecting the number of members for the advisory committees referred to in subsection 15.1(1);

valeurs et les objectifs généraux qui doivent être associés à la dispensation des services hospitaliers à l'établissement hospitalier,

b) déterminer les programmes et les services relatifs aux objectifs généraux qui sont essentiels pour réaliser les objectifs généraux établis dans la déclaration prescrite en vertu de l'alinéa a),

c) surveiller l'observance de la déclaration prescrite en vertu de l'alinéa a) et des programmes et services relatifs aux objectifs généraux déterminés en vertu de l'alinéa b), et

d) accomplir les choses additionnelles qui sont prescrites par règlement.

15.1(5) La philosophie, les valeurs et les objectifs généraux indiqués dans la déclaration prescrite en vertu du paragraphe (4) et les programmes et les services relatifs aux objectifs généraux déterminés en vertu du paragraphe (4) ne peuvent entrer en conflit avec les paramètres établis par le Ministre et les directives délivrées par celui-ci relativement à la planification, à l'organisation, à la gestion et la dispensation des services hospitaliers par les corporations hospitalières.

2 Le paragraphe 34(6) de la Loi est abrogé et remplacé par ce qui suit:

34(6) Une désignation qui est faite, un paramètre ou des lignes directrices qui sont établis, une directive qui est délivrée, une disposition qui est précisée ou une autorisation qui est donnée, suspendue ou révoquée par le Ministre en vertu de la présente loi ou des règlements ne constituent pas un règlement au sens de la *Loi sur les règlements*.

3 Le paragraphe 35(1) de la Loi est modifié

a) par l'adjonction après l'alinéa i) de ce qui suit:

i.1) concernant le nombre des membres des comités consultatifs prévus au paragraphe 15.1(1);

APPENDIX E

- (i.2)* respecting the designation of chairpersons for the advisory committees referred to in subsection 15.1(1), and the payment of honorariums to the chairpersons;
- (i.3)* respecting the reimbursement of the members of the advisory committees referred to in subsection 15.1(1) for expenses incurred by them as members of the advisory committees;
- (i.4)* respecting the reimbursement of the advisory committees referred to in subsection 15.1(1) for expenses incurred by the advisory committees in exercising their powers and carrying out their duties under this Act and the regulations;
- (i.5)* authorizing the Minister to establish guidelines
- (i) for the payment of honorariums to the chairpersons of the advisory committees referred to in subsection 15.1(1), and
 - (ii) for the reimbursement of the advisory committees referred to in subsection 15.1(1) and the members of those committees for the expenses referred to in paragraphs (i.3) and (i.4);
- (i.6)* prescribing additional powers and duties for the advisory committees referred to in subsection 15.1(1);
- (i.7)* respecting access by the advisory committees referred to in subsection 15.1(1) to hospital corporation personnel and to hospital corporation and hospital facility records for purposes directly related to the powers and duties of the advisory committees under this Act and the regulations;
- (b)* by repealing paragraph (x) and substituting the following:
- i.2)* concernant la désignation des présidents des comités consultatifs prévus au paragraphe 15.1(1) et le versement d'honoraires aux présidents;
- i.3)* concernant le remboursement aux membres des comités consultatifs prévus au paragraphe 15.1(1) des dépenses encourues par eux à titre de membres des comités consultatifs;
- i.4)* concernant le remboursement aux comités consultatifs prévus au paragraphe 15.1(1) des dépenses encourues par les comités consultatifs dans l'exercice de leurs pouvoirs et dans l'exécution de leurs fonctions en vertu de la présente loi et des règlements;
- i.5)* autorisant le Ministre à établir des lignes directrices
- (i) pour le versement d'honoraires aux présidents des comités consultatifs prévus au paragraphe 15.1(1), et
 - (ii) pour le remboursement aux comités consultatifs prévus au paragraphe 15.1(1) et aux membres de ces comités des dépenses visées aux alinéas i.3) et i.4);
- i.6)* prescrivant les pouvoirs et fonctions additionnels des comités consultatifs prévus au paragraphe 15.1(1);
- i.7)* concernant l'accès des comités consultatifs prévus au paragraphe 15.1(1) au personnel de la corporation hospitalière et aux dossiers de la corporation hospitalière et de l'établissement hospitalier aux fins qui sont directement reliées aux pouvoirs et aux fonctions des comités consultatifs en vertu de la présente loi et des règlements;
- b)* par l'abrogation de l'alinéa x) et son remplacement par ce qui suit:

APPENDIX E

(x) requiring the board of trustees of a hospital corporation to include in the bylaws of the hospital corporation provisions specified by the Minister to ensure the preservation in a hospital facility owned in whole or in part by a religious order of the philosophy, values and mission that have been associated with the delivery of hospital services in that hospital facility;

4 Sections 1, 2 and 3 of this Act come into force on a day or days to be fixed by proclamation.

x) requérant le conseil de fiduciaires d'une corporation hospitalière d'inclure dans les règlements administratifs de la corporation hospitalière des dispositions précisées par le Ministre pour assurer la préservation dans un établissement hospitalier appartenant en tout ou en partie à une communauté religieuse, de la philosophie, des valeurs et des objectifs généraux qui ont été associés à la dispensation des services hospitaliers dans cet établissement hospitalier;

4 Les articles 1, 2 et 3 de la présente loi entrent en vigueur à la date ou aux dates fixées par proclamation.

PROJECT OF LAW NO. 83

ENTITLED: An Act to Amend the Hospital Act
TITRE: Loi modifiant la Loi hospitalière

Amend said Bill as follows:

Amendement à apporter au projet de loi:

Section 1 Article 1	Subsection Paragraphe	Paragraph Alinéa	Subparagraph Sous-alinéa	Line No. Ligne No.
------------------------	--------------------------	---------------------	-----------------------------	-----------------------

In section 1 of the Bill add after subsection 15.1(5) the following:

15.1(6) The Minister shall not, in relation to a hospital facility for which there is an advisory committee, approve the delivery of hospital services that conflict with the philosophy, values and mission set out in a statement prescribed under subsection (4).

À l'article 1 du projet de loi ajouter après le paragraphe 15.1(5) ce qui suit:

15.1(6) Le Ministre ne peut, relativement à un établissement hospitalier pour lequel il existe un comité consultatif, autoriser la dispensation des services hospitaliers qui entrent en conflit avec la philosophie, les valeurs et les objectifs généraux indiqués dans une déclaration prescrite en vertu du paragraphe (4).

APPENDIX F

NEW BRUNSWICK REGULATION 92-84

H-6.1

Hospital Act

92-84



**NEW BRUNSWICK
REGULATION 92-84**

under the

**HOSPITAL ACT
(O.C. 92-508)**

**RÈGLEMENT DU
NOUVEAU-BRUNSWICK 92-84**

établi en vertu de la

**LOI HOSPITALIÈRE
(D.C. 92-508)**

H-6.1

Hospital Act

92-84

ADVISORY COMMITTEES

15.1(1) In this section

"advisory committee" means an advisory committee referred to in subsection 15.1(1) of the Act.

15.1(2) An advisory committee shall be made up of not more than eight members.

15.1(3) The religious order that owns in whole or in part a hospital facility for which there is an advisory committee shall designate one of the members of the advisory committee to be the chairperson of the committee.

15.1(4) The hospital corporation responsible for the operation of a hospital facility for which there is an advisory committee shall, in accordance with guidelines established by the Minister,

(a) pay an honorarium to the chairperson of the advisory committee,

(b) reimburse the members of the advisory committee for expenses incurred by them as members of the advisory committee, and

(c) reimburse the advisory committee for expenses incurred by the advisory committee in exercising its powers and carrying out its duties under the Act and the regulations.

15.1(5) The Minister may establish guidelines for the payment of honorariums to the chairpersons of advisory committees, and for the reimbursement of advisory committees and members of advisory committees for the expenses referred to in subsection (4).

15.1(6) An advisory committee shall provide to the Minister and to the board of trustees of the hospital corporation a copy of the statement prescribed under subsection 15.1(4) of the Act and shall indicate to the Minister and the board of trustees the mission programs and services determined by the advisory committee under subsec-

COMITÉS CONSULTATIFS

15.1(1) Dans le présent article

«comité consultatif» désigne un comité consultatif prévu au paragraphe 15.1(1) de la Loi.

15.1(2) Un comité consultatif se compose d'au plus huit membres.

15.1(3) La communauté religieuse à qui appartient en tout ou en partie un établissement hospitalier pour lequel est établi un comité consultatif désigne l'un des membres du comité consultatif à titre de président du comité.

15.1(4) La corporation hospitalière responsable de l'exploitation d'un établissement hospitalier pour lequel est établi un comité consultatif doit, conformément aux lignes directrices établies par le Ministre,

a) verser des honoraires au président du comité consultatif,

b) rembourser les membres du comité consultatif des dépenses qu'ils ont encourues à titre de membres du comité consultatif, et

c) rembourser le comité consultatif des dépenses qu'il a encourues dans l'exercice de ses pouvoirs et dans l'exécution de ses fonctions en vertu de la Loi et des règlements.

15.1(5) Le Ministre peut établir des lignes directrices pour le versement d'honoraires aux présidents des comités consultatifs, et pour le remboursement aux comités consultatifs et aux membres des comités consultatifs des dépenses visées au paragraphe (4).

15.1(6) Un comité consultatif doit fournir au Ministre et au conseil de fiduciaires de la corporation hospitalière une copie de la déclaration prescrite en vertu du paragraphe 15.1(4) de la Loi et doit indiquer au Ministre et au conseil de fiduciaires les programmes et les services relatifs aux objectifs généraux déterminés par le comité consul-

92-84

Loi hospitalière

H-6.1

tion 15.1(4) of the Act to be essential to fulfil the mission set out in the statement prescribed under subsection 15.1(4) of the Act.

15.1(7) The board of trustees of the hospital corporation shall ensure that the advisory committee has reasonable access, for purposes directly related to the powers and duties of the advisory committee under the Act and the regulations,

(a) to the chief executive officer of the hospital corporation,

(b) to the senior administrative officer and to medical and other staff at the hospital facility,

(c) to persons employed at the hospital facility, and

(d) to hospital corporation and hospital facility records that directly relate to the preservation of the religious character of the hospital facility, excluding clinical and financial records of individuals.

94-10

tatif en vertu du paragraphe 15.1(4) de la Loi comme étant essentiels à la réalisation des objectifs généraux établis dans la déclaration prescrite en vertu du paragraphe 15.1(4) de la Loi.

15.1(7) Le conseil de fiduciaires de la corporation hospitalière doit veiller à ce que le comité consultatif ait un accès raisonnable, aux fins reliées directement aux pouvoirs et fonctions du comité consultatif en vertu de la Loi et des règlements,

a) au directeur général de la corporation hospitalière,

b) à l'agent administratif senior et au personnel médical et à tout autre genre de personnel de l'établissement hospitalier,

c) aux personnes employées à l'établissement hospitalier, et

d) aux dossiers de la corporation hospitalière et de l'établissement hospitalier qui sont reliés directement à la préservation du caractère religieux de l'établissement hospitalier, sauf les dossiers cliniques et les dossiers financiers des particuliers.

94-10

92-84

Loi hospitalière

H-6.1

which history and findings shall be sufficient to enable the anaesthetist to choose a suitable anaesthetic for the patient.

46(3) Where a surgeon or dental practitioner is of the opinion that the delay caused by preparing the record referred to in subsection (2) would be detrimental to the patient and delivers to the anaesthetist a statement to this effect, the anaesthetist may prepare the record referred to in subsection (2) after the operation is completed.

46(4) The statement referred to in subsection (3) shall become part of the patient's clinical record.

46(5) Each time an anaesthetist administers an anaesthetic to a patient, the anaesthetist shall prepare a report showing the type of anaesthetic given, the amount used, the length of time the anaesthetic was given and the condition of the patient before, during and after the operation.

93-6

GENERAL

(47) The board of trustees of a hospital corporation shall include in the by-laws of the hospital corporation provisions specified by the Minister to ensure the preservation in a hospital facility owned in whole or in part by a religious order of the philosophy, values and mission that have been associated with the delivery of hospital services in that hospital facility.

94-10

48 The Minister may visit a hospital facility at any time for the purpose of an inspection or any inquiry regarding the physical plant, equipment and furnishings, operation or the general administration of the hospital facility.

49 The Minister may

(a) inspect and inquire with respect to the premises, management and operation of a hospital facility,

(b) require a chief executive officer

cette histoire et ces résultats doivent être suffisants pour permettre à l'anesthésiste de choisir l'anesthésique approprié pour le malade.

46(3) Lorsque le chirurgien ou le dentiste estime que le retard occasionné par la préparation du dossier visé au paragraphe (2) serait préjudiciable au malade et transmet à l'anesthésiste une déclaration à cet effet, l'anesthésiste peut établir le dossier visé au paragraphe (2) après l'intervention chirurgicale.

46(4) La déclaration mentionnée au paragraphe (3) fait partie du dossier clinique du malade.

46(5) Chaque fois qu'il administre un anesthésique à un malade, l'anesthésiste doit préparer un rapport indiquant le genre d'anesthésique administré, la quantité utilisée, la durée de l'anesthésie et l'état du malade avant, pendant et après l'intervention chirurgicale.

93-6

DISPOSITIONS GÉNÉRALES

47 Le conseil de fiduciaires d'une corporation hospitalière doit inclure dans les règlements administratifs de la corporation hospitalière des dispositions spécifiées par le Ministre pour assurer la préservation dans un établissement hospitalier qui appartient en tout ou en partie à une communauté religieuse, de la philosophie, des valeurs et des objectifs généraux qui ont été associés à la dispensation des services hospitaliers dans cet établissement hospitalier.

94-10

48 Le Ministre peut à tout moment visiter un établissement hospitalier en vue d'y procéder à une inspection ou à une enquête concernant les bâtiments, le matériel, l'ameublement et le fonctionnement ou l'administration en général.

49 Le Ministre peut

a) mener inspection et enquête concernant les locaux, l'administration et le fonctionnement d'un établissement hospitalier

b) obliger le directeur général à

APPENDIX G

LETTER OF COMFORT

April 11, 1995

New
Nouveau  Brunswick

Mr. George Martin
Chairman
N. B. Catholic Health Association
51 Lobban Avenue
Miramichi, New Brunswick
E1N 3W4

Dear Mr. Martin:

I am writing following your correspondence of October 11th, 1994 which was received in our office on November 15th. I specifically wish to provide a written expression of the intent of sections 15.1(5) and (6) and 32.1(3)(a) and (b) of the Hospital Act (1993).

It is the government's view and intent that sections 15.1(5) and 15.1(6) are interdependent and that they should not be read and considered separately. While it is true that 15.1(5) limits the scope of the philosophy, values and mission statement(s), it is important to note that the Minister's ability to plan, organize and manage the delivery of hospital services is also limited and contained by 15.1(6). Indeed, the Minister cannot "approve the delivery of hospital services that conflict with the philosophy, values and mission" of those institutions for which there is an advisory committee. The parameters and directions referred to in section 15.1(5), which may limit the scope of the mission statement, would deal only with general prescriptions of the number and types of services and beds contained in the Hospital System Master Plan, or in the regional service plans which complement and implement the Master Plan. I want to assure you that the government intends to abide by that limitation.

Section 32 of the Hospital Act was introduced in response to the concern expressed by the Catholic Religious Orders that the original Hospital Act prohibited the establishment of private religious hospitals outside the Region Hospital Corporations. Section 32.1 (3)(a) and (b) relates to the terms and conditions for establishing such private facilities and should be read in that context and also in relation with paragraphs 12 and 13 of the Letter of Understanding (1993). Recognizing that the government has no obligation to fund such institutions, any terms and conditions would deal only with issues of public safety and security.

I trust the above clarifies the intent of the legislation and provides comfort to the New Brunswick Catholic Health Association.

Sincerely,


RUSSELL H.T. KING, M.D.
MINISTER



Tel./Téléphone:
(506) 453-2581

P.O. Box 5100
Fredericton
New Brunswick
Canada E3B 5G8

Cas. postale 5100
Fredericton
Nouveau-Brunswick
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APPENDIX H

**REQUIRED BYLAW WORDING OF REGION HOSPITAL
CORPORATION BYLAW**

Revised
1995-04-07

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

REQUIRED BY-LAW WORDING

REGION HOSPITAL CORPORATION BY-LAW

This by-law is in compliance with Section 35(1) (x) of the Hospital Act and Section 47 of Regulation 92-84 under that Act.

1. The Region _____ Hospital Corporation shall carry out its assigned role in relation to the management and operation of the _____ hospital facility in accordance with the April 21, 1993, Letter of Understanding between the Province of New Brunswick, the Catholic Religious Orders and the New Brunswick Catholic Health Association, as reflected in the provisions of Section 15.1 of the Hospital Act and Section 15.1 of Regulation 92-84 under that Act.

More specifically:

The Philosophy Statement and Mission Statement approved by the Advisory Committee shall be adhered to by the Region Hospital Corporation once the Minister and the Congregation have agreed, in writing that they are appropriate.

The name and characteristics of the facility will be preserved, as per the Letter of Understanding and paragraphs 4 and 5 of Schedule C of the Lease.

The facility administrator job description for a hospital facility owned by a Catholic Religious Order and managed/operated by a Region Hospital Corporation will be consistent with the version issued by the Department of Health and Community Services and dated January 25, 1994.

The process for selecting a facility administrator outlined in the Letter of Understanding will be adhered to by the Corporation and the Religious Order.

Facility staff will agree in writing to abide by the approved Mission Statement, as per the Letter of Understanding.

2. The relationship between the Advisory Committee and the Region _____ Hospital Corporation shall also be in keeping with the provisions of the Letter of Understanding, as reflected in Section 15.1 of the Hospital Act and Section 15.1 of Regulation 92-84 under that Act.

APPENDIX I

GENERAL POSITION DESCRIPTION FOR ADMINISTRATOR OF CATHOLIC RELGIOUS HOSPITAL FACILITY

APPENDIX I

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES GENERAL POSITION DESCRIPTION FOR ADMINISTRATORS OF CATHOLIC RELIGIOUS HOSPITAL FACILITIES

327

(Note: there may be some variations due to facility size and service range differences and also differences in Region Hospital Corporation organizational structures).

POSITION TITLE: Facility Administrator

POSITION SUMMARY:

The facility administrator of a Catholic religious hospital facility shall be responsible for the effective and efficient day to day operation of the facility. The facility administrator shall participate in the organization and direction of the activities and programs of the facility in a manner consistent with the operational policies of the Region Hospital Corporation, its By-laws and Strategic Plan, as well as the New Brunswick Hospital system Master Plan and related parameters and guidelines issued by the Minister of Health and Community Services and all applicable statutes and regulations of New Brunswick and Canada.

The facility administrator shall also be responsible to ensure that the operation of the hospital facility achieves the objectives of the mission statement of the facility developed by the facility's Advisory Committee and accepted by the Corporation's Board and complies with the specific provisions of the Hospital Act and Regulations, the Corporation's By-laws and the Agreement between the Catholic religious Orders and the Province of New Brunswick relating to preservation of the character, values and philosophy of a Catholic religious hospital facility.

The facility administrator is an employee of the Province of New Brunswick under Part J of the New Brunswick Public Service labour Relations Act. On a day-to-day operational basis, the facility administrator is a member of the management staff of the relevant Region Hospital Corporation.

REPORTING RELATIONSHIPS:

1. Reports to the Region Hospital Corporation CEO or his/her designate, to whom the facility administrator is responsible for the operation of the hospital facility.
2. Reports, in an advisory/liaison relationship, to the Advisory Committee of the hospital facility in regard to implementation of the mission statement and in compliance with the Hospital Act and Regulations, the By-laws and the Agreement between the Catholic Religious Orders and the Province of New Brunswick as they relate to the preservation of the character, values and philosophy of a Catholic religious hospital facility.

APPENDIX I

2

328

REGULAR DUTIES AND RESPONSIBILITIES:

1. Ensures safe and cost-efficient operation of the facility's structure and equipment.
2. Participates in the preparation of the hospital facility budget and is responsible for the financial aspects of the facility and its operations, as delegated by the CEO or his/her designate.
3. Ensures the appropriate implementation of both the Region Hospital Corporation and facility mission statements.
4. Coordinates and integrates the various activities of the facility to ensure optimum utilization of available resources.
5. Interprets Hospital Corporation objectives and policies to facility employees and ensures these policies are implemented. Also ensures specific hospital facility objectives and policies are consistent with those of the Corporation.
6. Supervises hospital facility personnel, is a designated level in the grievance procedure for facility staff and maintains discipline.
7. Ensures that staffing and resources are scheduled in such a manner as to meet the daily workload requirements.
8. Participates in the selection and appointment process for all staff reporting directly to the facility administrator.
9. Gives leadership in problem solving and control of activity.
10. Maintains an effective working relationship with medical practitioners ensuring that the values, philosophy and mission of the Catholic hospital facility are maintained in policies and procedures.
11. Agrees in writing and ensures that all Region Hospital Corporation employees, medical practitioners and others providing health care services in the hospital facility, have agreed in writing to abide by the mission statement of the facility in effect from time to time.
12. Cooperates with the Advisory Committee in identifying programs and services the Committee considers to be essential to implement the mission statement as it relates to the preservation of the character of the religious hospital and in implementing approved, funded programs and services.
13. Cooperates in the establishment and implementation of a Pastoral Care Coordination Program to assure that pastoral care services are available to hospital patients.
14. Cooperates with the Advisory committee in providing reasonable access to hospital facility Committees, staff and records that

APPENDIX I

directly relate to enabling the Committee to fulfill its role.

15. **Attends Advisory Committee meetings.**
16. **Attends Region board meetings at the request of the CEO or his/her designate or by invitation of the Board..**
17. **Demonstrates an interest in professional advancement for self and effectively encourages others toward this goal, e.g. attendance at educational seminars sponsored by a variety of organizations, including the New Brunswick Catholic Health Association and Catholic Health Association of Canada.**
18. **Communicates with Region officials, with local interest groups, civic bodies and the public in the context established by Region Hospital Corporation policies.**
19. **Familiarizes himself/herself with the contents of the following: Hospital Act and Regulations, Region Hospital Corporation By-laws, the New Brunswick Hospital System Master Plan, the Hospital Corporation's Strategic Plan, the Agreement between the Catholic Religious Orders and the Province of New Brunswick, the Catholic Health Care Ethics Guide and the hospital facility's mission statement.**

POSITION SPECIFICATIONS:

1. **Education:**

Advanced education at the Baccalaureate or Masters level in a health related field, preferably health administration. In lieu of university education, the candidate must have formal training in management, such as Canadian Hospital Association's Health Services Organization and Management program or equivalent.

2. **Experience:**

Previous experience in health services administration.

3. **Personal:**

The following skills are considered to be important for this position:

- **strong interpersonal, leadership and team-building skills;**
- **ability to function effectively as a member of the corporation's management team;**
- **commitment to the values, philosophy and mission of a Catholic religious hospital facility.**

4. **Knowledge:**

Good working knowledge of the health care system, including the laws and regulations governing it.

APPENDIX J

TERMS OF REFERENCE ADVISORY COMMITTEE

TERMS OF REFERENCE

ADVISORY COMMITTEE
(NAME OF CATHOLIC HOSPITAL)
(ADDRESS)

331

MANDATE

The Advisory Committee is a statutory body created pursuant to the provisions of the Hospital Act. The mandate of this committee as prescribed in the Act, is to ensure the preservation of the Catholic religious character of (Name of Catholic Hospital), (Address)

The Advisory Committee provides advice and guidance to the Region Hospital Corporation on the content of the Hospital's mission statement and ensures that hospital services and operations are consistent with that mission statement and implement it.

More detailed provisions describing the Committee's role are contained in Regulations enacted pursuant to the provisions of the Hospital Act, and in an Agreement between the Province of New Brunswick and the owners of the seven Catholic religious hospitals in the Province.

Region __ Hospital Corporation is required to enact the standard by-law wording adopting the mission statement, and prohibiting services that would be in conflict with it.

Copies of the relevant provisions of the Hospital Act and Regulations, the Region Hospital Corporation By-laws, and the Agreement, are attached.

APPOINTMENTS

Advisory Committee members are selected and appointed by the owner of the Hospital, (Name of Religious Congregation), and the Committee reports to that Congregation. The (Name of religious Congregation) also determines how many members will constitute the Advisory Committee, subject to a maximum of eight, and designates the chairperson.

ROLE

The Advisory Committee's role is to carry out the following responsibilities with respect to (Name of Catholic Hospital)

1. Ensure the preservation and character of the Catholic religious of the Hospital as expressed in the mission statement and the Catholic Health Care Ethics Guide.
2. Develop the mission statement of (Name of Catholic Hospital) as it relates to the Catholic religious character of the Hospital.
3. Develop amendments or revisions of the mission statement from time to time as may be necessary or desirable.
4. Verify that the administrator, employees, medical practitioners and others, including Region employees, providing hospital care services in the Hospital have agreed in writing to abide by the mission statement in effect from time to time.
5. Determine the Hospital mission programs and services essential to implement the mission statement and preserve the Catholic religious character of the Hospital. This includes determining program content and delivery agent(s) and covering the direct program cost, as well as direct pastoral care costs. (The Region Hospital Corporations will cooperate in arranging programs and staff availability to attend these courses/programs, as needed, and will cover staff replacement costs. The

APPENDIX J

Corporations will also cover pastoral care coordination costs).

6. Monitor the operation of the Hospital to ensure that the programs and services determined by the Committee are satisfactorily implemented.
7. Formulate and recommend to the Region Hospital Corporation Board any corrective measures necessary to satisfactorily implement those programs and services.
8. Appoint 50% of the members of the interview panel which must be constituted to recommend the appointment of an individual to fill a vacancy in the position of facility administrator of the Hospital.
9. Monitor the role and responsibility of the facility administrator as delegated and assigned to by the Region C.E.O. to ensure that it is consistent with the job description and the relevant provisions of the Act, Regulations, By-laws and Agreement.
10. Monitor the performance of the facility administrator in fulfilling his/her job responsibility to operate the Hospital as a religious hospital and in accordance with the relevant provisions of the Act, Regulations, By-laws and Agreement.
11. Monitor committees, interview staff, and review records, of the Hospital as may be relevant and necessary to carry out the Committee's role and responsibilities
12. Formulate and recommend to the Region Hospital Corporation Board the steps necessary to ensure compliance with the provisions of the Act, Regulations, By-laws and Agreements that relate to the religious character of the Hospital.
13. Maintain appropriate communication and relationships between the Committee's chairperson, and the Region C.E.O. and the facility administrator as may best facilitate fulfilling the role and responsibilities of the Committee.
14. Ensure that the Hospital maintains active institutional membership in the New Brunswick Catholic Health Association and the Catholic Health Association of Canada, and that the Committee and the Hospital maintain active participation in those associations.
15. Report to (Religious Congregation) in the manner requested by the Congregation with respect to fulfilment of the Committee's terms of reference, and implement such remedial measures as may be identified by the Congregation from time to time.

FUNDING

Reimbursement for the reasonable expenses and costs of the Committee is included in the annual payment by the province to the New Brunswick Catholic Health Association on behalf of the owners of all of the Catholic hospitals in the Province.

APPENDIX K

LEASE

APPENDIX K

Standard Forms of Conveyances Act, S.N.B. 1980, c.S-12.2, s.2

The parties to this lease are:

334

(Religious Congregation) and (Name of Hospital), a body corporate established by private statute, the "lessors"

- and -

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK,
as represented by the Minister of Supply and Services, and **REGION _____ HOSPITAL CORPORATION,** a body corporate established by the Hospital Act, the "lessees".

The lessors lease to the lessees the parcel described in Schedule "A" attached hereto on the following conditions:

Duration	15 years.
Date of Commencement:	April 1, 1992
Date of Termination:	March 31, 2007.
Rent:	\$1.00 per annum.
Payments:	Annually, on April 1st each year.
Place of Payment:	(Head Office of Owner's Corporation)

This lease contains the covenants and conditions which are set out in:

- (a) the Leases Regulation - Standard Forms of Conveyances Act and set out in Schedule "B" attached hereto; and
- (b) Schedule "C" attached hereto

The recitals contained in Schedule "D" attached hereto form part of this lease.

DATED as of April 1, 1992.

(RELIGIOUS CONGREGATION	)	(RELIGIOUS HOSPITAL CORPORATION)
_____	)	_____
_____	)	_____
_____	)	_____
_____	)	_____
_____	)	_____
_____	)	_____

REGION _____ HOSPITAL CORPORATION)	HER MAJESTY THE QUEEN IN
_____)	RIGHT OF THE PROVINCE OF
_____)	NEW BRUNSWICK
_____)	_____
_____)	Minister of Supply and Services
_____)	

APPENDIX K**SCHEDULE "A"**

The land and facilities covered by this lease are as follows:

(DESCRIPTION OF PROPERTY)

APPENDIX K**SCHEDULE "B"**

11. The lessees shall pay rent.
12. The lessees shall maintain the premises in good repair.
13. The lessees shall permit the lessor to inspect the premises.
15. The lessees shall use the premises for agreed purposes only.
17. The lessees shall comply with all laws.
18. The lessees shall deliver vacant possession upon termination of the lease.
22. The lessees shall pay occupancy taxes.
26. On breach of any covenant the lessors may recover all costs from the lessees as rent
28. The lessors promises to the lessees quiet enjoyment of the premises.
33. The lessees has an insurable interest in improvements made by them.
35. The lessors may make changes to pipes, conduits and ducts.
36. Where the lessees holds over the tenancy is monthly.
38. The lessors are not responsible for injury to persons or property upon the premises unless due to the negligence of the lessors.
39. The lessees may install signs with the lessors consent.
41. Condonation, excuse or overlooking of any default does not operate as waiver.
42. All lessees insurance policies shall contain a waiver of subrogation.
46. The lessors may re-enter the premises upon non-payment of rent or other breach.

APPENDIX K

337

SCHEDULE "C"

This lease is entered into by the lessors and the lessees subject to the following covenants and conditions:

- 1. In the event of conflict or inconsistency between the covenants and conditions contained in Schedule C and the covenants and conditions contained in Schedule B, those contained in Schedule C shall prevail.**
- 2. In this lease, "hospital facility" shall mean the parcel leased as described in Schedule A, including its contents.**
- 3. This lease is entered into by the lessors and lessees for the use and occupation of the hospital facility by the lessees solely for the provision of hospital services in accordance with the Hospital Act and the Hospital System Master Plan.**
- 4. The hospital facility shall be identified under the following name -(Name of Hospital) This name shall be used to refer to the hospital facility for all purposes, internal and external, that require specific identification of this facility by the Province of New Brunswick and the Region __ Hospital Corporation. This provision does not extend to this hospital facility having its own letterhead, separate and distinct from that used by the Region __ Hospital Corporation and the other facilities it operates, except as may be authorized by the Region __ Hospital Corporation to identify any particular facility. Notwithstanding the foregoing, identification of the hospital facility in letterhead and other printed documents and publications shall include the logos or symbols that reflect its religious character and its association with the (Name of Religious Congregation).**
- 5. The lessees agree that the religious character and history of association of the hospital facility with the lessors, as reflected in the physical features furnishings and other visual aspects of the hospitals, including the buildings and grounds, shall remain and shall be maintained in the same form as existed on April 1, 1992.**
- 6. The lessees, Region __ Hospital Corporation, agrees that the hospital facility will be operated by it in a manner consistent with the provisions of section 15.1 of the Hospital Act, the provisions of the Letter of Understanding, and the Agreement.**
- 7. No person shall be employed to work in the hospital facility, and no medical practitioner or other person shall be permitted to use the facilities to provide medical or other services, unless that person has agreed in writing, on a form prepared and retained by the administrator, to abide by the mission statement in effect from time to time at the hospital facility.**
- 8. Following consultation with the Advisory Committee established pursuant to the Hospital Act, the lessees may erect any building on the leased lands, or make any improvement to the existing buildings or alter the interior of the buildings if reasonably required to provide hospital services in accordance with the provisions of the Hospital System Master Plan.**
- 9. The lessees shall not, without the consent in writing of the lessors, remove or destroy any building or a portion of any building. In the event of damage to, or destruction of, any building, fixtures or contents, the lessees shall compensate the lessors for the value thereof in accordance with the value of the lessors equity in the building, fixture or contents.**

10. On the expiration or termination of this lease the lessees will promptly vacate the hospital facility, repairing any damage caused thereby, and shall leave in place any building service equipment installed by the lessees.
11. The lessors, the Advisory Committee, and any persons authorized by them, shall have a right of access to the hospital facility as may be reasonably necessary to carry out its functions and responsibilities as set out in the Hospital Act and Regulations, the Letter of Understanding, and the Agreement, and as may be required for its use and occupation of adjacent lands and premises, including use of existing parking areas on the leased lands.

"Right of access" is defined to include a requirement of reasonable advance notice and shall not interfere with the regular operation of the hospital facility.
12.
 - (1) The lessees agree to pay all costs arising out of their use, occupancy, operation and maintenance of the hospital facility. Costs of operation and maintenance shall include, but not be limited to, taxes, utilities, heat, security, snow removal and repair. This obligation arises as of April 1, 1992 and any such costs paid by the lessors after that after that date will be reimbursed by the lessees to the lessors; all other such costs shall be paid directly by the lessees as they become due.
 - (2) The lessees agree to pay for the duration of this lease all taxes, rates, duties and assessments whatsoever, whether municipal, provincial federal or otherwise, now charged or hereafter to be charged upon the demised premises or upon the lessors, or either of them, on account thereof. This obligation arises as of April 1, 1992 and any such costs paid by the lessors, or either of them, after that date will be reimbursed by the lessees to the lessors on demand.
 - (3) The lessees acknowledge and agree that the lessors are not responsible during the term for any costs, charges, expenses and outlays of any nature, whether arising from or relating to the use and occupancy of the premises, or the content thereof, or any activity or business carried on therein.
13. The lessees agree that the lessors shall not be liable for any claim, damage, loss or costs arising out of any repairs, alterations or construction carried out by or on behalf of the lessees, or for personal injury or death of any person, or any damage to, or loss of, any person's property, including the costs of defending any such claim, arising out of the operation of the hospital facility or the lessor's ownership thereof. The lessee agrees that it will indemnify, preserve and save harmless the lessors from any or all such claims including those of the lessees, their employees, contractors, invitees and licensees, patients, medical practitioners and adjacent landowners arising out of the operation of the hospital facility. The lessees agree that it will indemnify, preserve and save harmless the lessors from any or all loss and costs suffered by the lessors arising out of damage, destruction or any other form of loss to the hospital facility during the term of the lease. This provision shall apply to any event occurring in whole or in part on or after April 1, 1992.
14.
 - (1) The lessors and the lessees agree that the lessee, the Province of New Brunswick, shall provide an annual payment for the hospital facility, as provided in paragraph (2), for the purpose of enabling the intent and provisions of the Letter of Understanding to be fulfilled with respect to:
 - (i) The provision of education and training programs for hospital facility personnel related to the mission statement and pastoral care.

APPENDIX K

- (ii) maintaining active institutional Catholic Health Association memberships for the hospital facility.
- (iii) payment of an honorarium, and the costs and expenses of the Advisory Committee and its members incurred in carrying out the powers and duties of the Committee.

(2) The annual funding shall be in the amount of \$150,000 to be shared in common for the same purpose with the other Catholic hospitals, and paid in April each year to the New Brunswick Catholic Health Association on their behalf. The amount of the annual funding shall be increased each year by the percentage increase in that year of the hospital services program budget.

- 15. This lease may be terminated by either the lessors or the lessees at any time on the expiration of 12 months notice in writing given to the other party.
- 16. The lessors hereby gives to the lessees an option to renew this lease for a further term of 15 years upon the same terms and conditions except rent, but including this option for further renewal. This option may be exercised by the lessee by notice in writing delivered to the lessors at least 1 year prior to the expiration of the term.
- 17. The rent payable for any renewed term shall be as agreed upon by the parties at the time of the exercise of the lessees option to renew.
- 18. The lessees may assign its rights under this lease with the consent of the lessors, which consent shall not be unreasonably withheld.
- 19. The failure of the lessors to insist upon strict compliance with any term of this lease shall not be deemed a waiver of the same, or of any similar right or power at any subsequent time, or of any other provision.
- 20. The obligations of the lessees hereunder (other than the obligation of the Province of New Brunswick under Paragraph (4)) shall be joint and several.

APPENDIX K**SCHEDULE "D"**

WHEREAS (Name of Religious Congregation) are the owners of (Name of Catholic Facility) hospital facility.

AND WHEREAS the Province, the New Brunswick Catholic Health Association and the Catholic Religious Orders have undertaken a joint review of debts/liabilities, assets and equity in relation to each religious hospital facility,

AND WHEREAS (Name of Religious Congregation) operated this hospital facility from its establishment in (Year) until the enactment of the Hospital Act in 1992,

AND WHEREAS (Name of Religious Congregation) and the Province of New Brunswick entered into a Letter of Understanding dated April 21, 1993, one term of which was that the parties would enter into a lease governing the use of the hospital facility,

AND WHEREAS the lessees agree to lease the hospital facility so as to continue the provision of hospital services therefrom in accordance with the provisions of the Hospital Act,

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PART I CANON LAW

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March 26, 1992	Most Rev. J. Edward Troy, Bishop of Saint John
March 28, 1992	Sister Marion Garneau, SCIC, General Superior
March 28, 1992	Sister Estelle Mazerolle, RHSJ, President of the Board of Governors
March 30, 1992	Sister Ernestine Boudreau, f.j. Treasurer of the Corporation
March 30, 1992	Sister Audrey Mantle, RHSJ, Provincial Superior
April 12, 1992	Most Rev. Donat Chiasson, Archbishop of Moncton
April 23, 1992	Most Rev. J. Edward Troy,
May 21, 1992	Most Rev. Donat Chiasson
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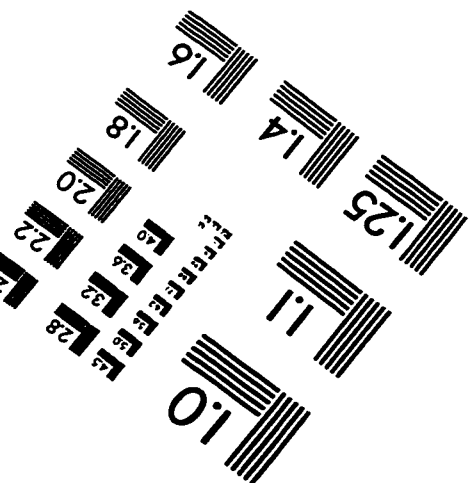
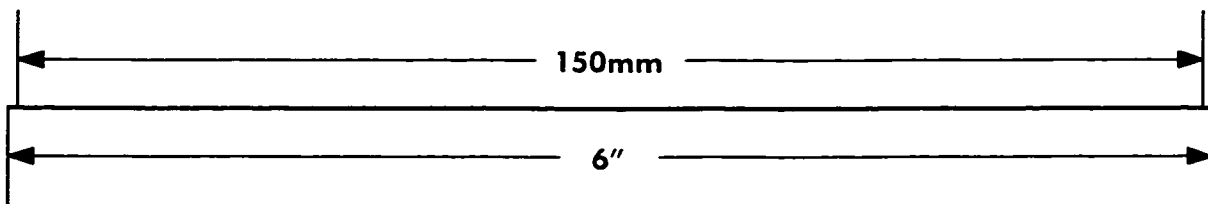
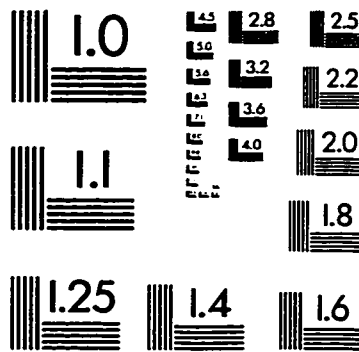
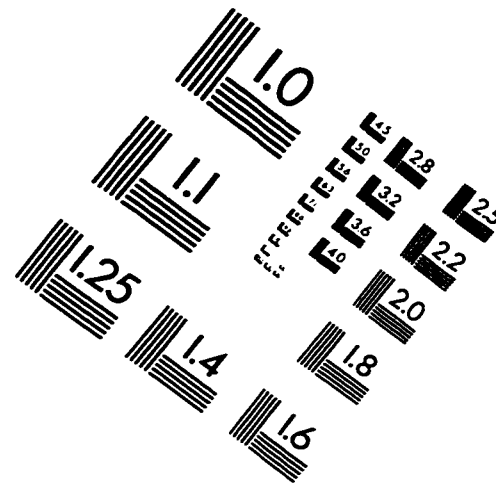
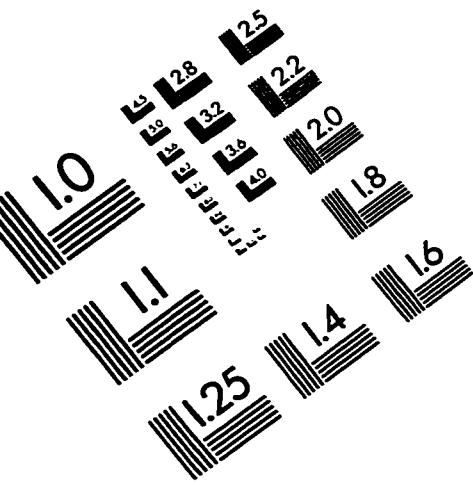
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BIOGRAPHICAL NOTE

Reverend Michael Dennis 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's, obtaining the Licentiate degree in 1996. In that same year he was appointed a judge of the Halifax Regional Matrimonial Tribunal and began doctoral studies in the fall of 1996.

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