The Great Canadian Catholic Hospital History Project

Documenting the legacy and contribution of the Congregations of Religious Women in Canada, their mission in health care, and the founding and operation of Catholic hospitals.

Projet de la Grande Histoire des hôpitaux catholiques au Canada

Retracer l'héritage et la contribution des congrégations de religieuses au Canada, leur mission en matière de soins de santéainsi que la fondation et l'exploitation des hôpitaux catholiques.

Hotel Dieu Hospital, Kingston
150 Years: 1845-1995
The House of Tender Mercy
Continuing to Serve

by
Jessie V. Deslaurieers

Source: Courtesy of the RHSJ St. Joseph Region Archives, Kingston

Digitized: March 2015


1845+1995

Hotel Dieu Hospital Kingston

1845 - 1995

The House of Tender Mercy

Continuing to Serve

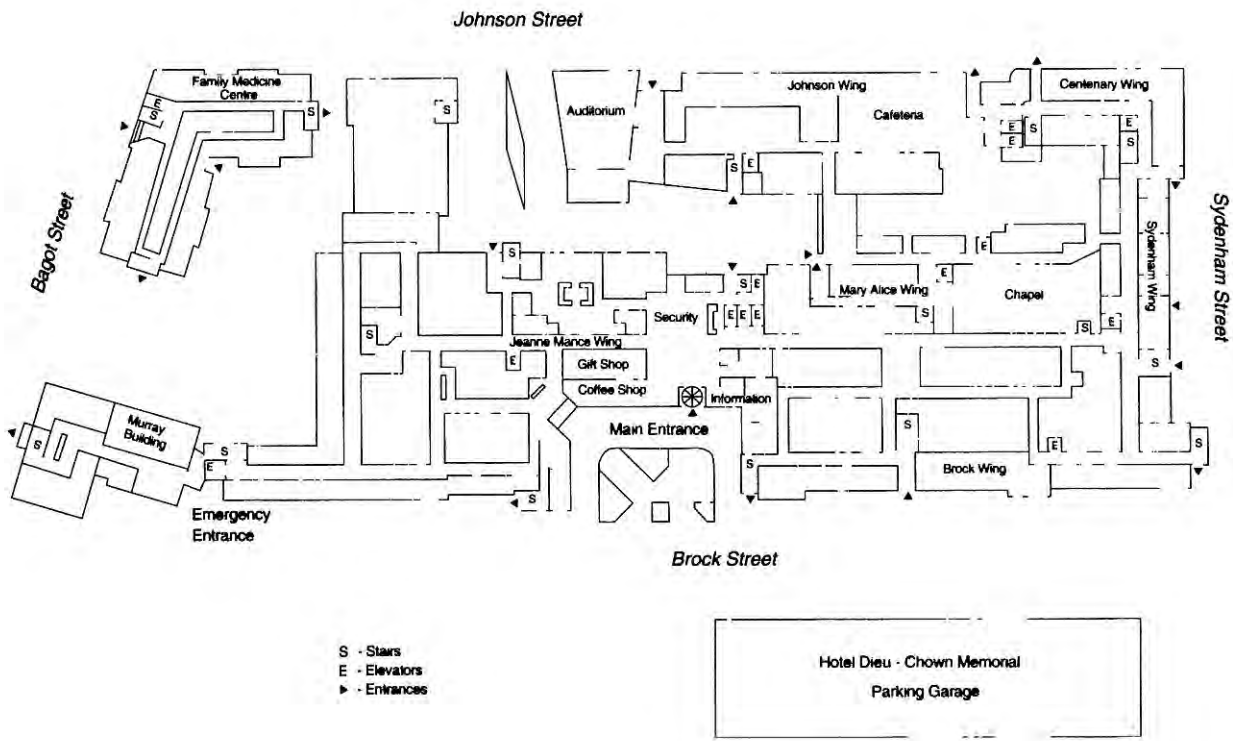
Jessie V. Deslauriers

They named you well who called you "House of God."
O title apt! Whose very words proclaim
The tender mercy preached by Him Who trod
The ways of Galilee. Your end and aim
Like His, to heal the sick, do good to all,
And teach the wayward on His Name to call.

From: "The Hotel Dieu", by Rev. D.A. Casey, in
"Souvenir Leaves 1845-1920, Hotel Dieu
of St. Joseph, Kingston, Ontario."

ISBN 0-9699666-0-1
Typography: Jennifer Shea
Design: Jennifer Shea & Alan Brown
Printing: Brown & Martin Limited, Kingston, Ontario

Hotel Dieu Hospital - Kingston



Acknowledgement

Like the Hotel Dieu itself, this book has been a truly collaborative effort among a number of caring and dedicated persons. These people deserve a huge vote of thanks: to **Jessie Deslauriers**, the author, for the countless hours spent doing research and conducting oral interviews, and then distilling what she had gathered into a lively and highly readable text; the members of the Book Subcommittee, who volunteered many hours and attended many meetings and who among a myriad of other duties and responsibilities proved beyond any doubt that a manuscript can be produced and published by committee: **Marilyn Braden, Sister Loretta Gaffney, Heather Gordon, Mary Millar, Mona Splinter** - thank you (and **Mary O'Connor** who while unable to attend in person was certainly present in spirit); to the **Jeanne Mance Foundation**, whose vision and commitment made this project possible in the first place; and to **Jennifer Shea** whose expertise, knowledge and long hours of dedication transferred the manuscript from a group of electronic impulses to camera-ready copy, our deep gratitude and thanks.

And to the reader - enjoy what follows!

Paul Banfield, Chair
Book Sub-committee

Foreword

Hotel Dieu is more than bricks and mortar. A "Catholic hospital," it is a community of concern, far beyond mere competence, responsibility and service. It is the Church in action, and an expression of the conviction that those who work in a hospital have the power to change the lives of all those who enter, and in turn are changed.

Hotel Dieu Kingston is a Catholic facility founded and maintained by the Religious Hospitallers of St. Joseph. Its values, mission and philosophy therefore are all based on those of the Congregation, and are reflected in the character of the hospital itself. It has become a living, breathing organic thing, according to Duncan Sinclair, Vice-Principal Health Sciences at Queen's University. "Hotel Dieu has a character that has been enriched tremendously by those dedicated women who have built it and have poured their lives into it. I can feel it when I walk in the halls of the hospital. I believe that that constitutes an intangible beyond price, and I have great admiration for the dedication and the selflessness of the Sisters, but also for their tremendous capacity to adapt and change to modern circumstances and do so with grace and with a decisiveness that, were it to be exhibited elsewhere, I think would serve us all well."

The Sisters are becoming few in number. The multiplicity of modern choices is taking its toll of those who might otherwise opt for a lifetime commitment to worship and apostolic service. But fortunately, the values held since the Order was first founded and since the handful of Sisters established that tiny hospital in Kingston, are being lived today. The tender compassionate care is still present, as shown by letters from patients. Even in times of controversy, the Hospital has maintained the first principles of love, care and compassion, as in the decision to assume care of those stigmatized by society, the lawbreakers or the mentally ill.

Sister Rosemarie Kugel, President of the Religious Hospitallers of St. Joseph Health System, relates that "Hotel Dieu's unique care will continue into the next century, as the laity assume responsibility and their leadership role in the ministry of healing and health care."

Jessie V. Deslauriers

This book develops aspects of the history of Hotel Dieu which illustrates the charism of the Religious Hospitallers of Saint Joseph, that of tender compassion.

At its foundation in 1845, three religious came in faith, responding to the cries of the poor and the sick. What boldness and courage marked the beginnings of this project for giving care.

As can well be imagined, all this was not accomplished without difficulties, challenges to be met and suffering. Our predecessors followed in the path common to all who strive to build a better world according to Gospel values.

I hope that those who read this one hundred and fifty year history of service will discover the roots which continue to nourish the hearts and spirits of those who work within this Hotel Dieu.

"The house of tender mercy", from its small beginning on Brock Street has become the institution you see today. It is still "continuing to serve".

May the example of those who have gone before be an inspiration for us in the present and carry forward into the future.

Denise Lafond, R.H.S.J.
Superior General
Religious Hospitallers of Saint Joseph

***

Caring enough about the sick brought the first R.H.S.J. to Kingston in 1845, at the invitation of Bishop Gaulin. They had no way of knowing...

- *that one would die as a result of her dedication to the sick*
- *that ways of caring for the sick would improve as drastically as their mode of travel*
- *that future Sisters from Kingston would care enough to found other "houses of tender mercy".*

Many professionals and non-professionals supported and enabled this mission to grow and prosper. Beneficiaries have been the sick, homeless, poor, and hungry in body and spirit.

The water continues to flow which brought these first R.H.S.J. Caregivers to Kingston. So, also, does Caring and Compassion flow in and through all who serve and support our mission today.

So, we ***celebrate****, and thank our Loving and Merciful God who inspires and challenges us to continue caring and serving the sick and less fortunate.*

Sister Anne Russell, R.H.S.J.
Provincial Superior, Saint Joseph Province
Religious Hospitallers of Saint Joseph

***

For the past one hundred and fifty years Hotel Dieu Hospital, as a Catholic health care institution, has had the challenge of supplying the best possible health care in a manner and in an atmosphere inspired by the gospel of Christ and of working for exemplary standards of hospital care.

As we reflect on the past, it is most obvious that the Religious Hospitallers of Saint Joseph and those who served with them have responded most faithfully and capably to this challenge and to the tradition of mercy of the Hotel Dieu Sisters. Hotel Dieu Hospital has been always faithful to the Sisters' mission of announcing the Good News of Jesus Christ by service to the sick and to the poor, and by education.

May the publication of this history and the celebration of the hundred and fifty years of service be the occasion of thanksgiving for and renewal of the Sisters' heritage that has been rich in determination, commitment and love in bringing Christ's healing ministry to those in need in our communities.

May this service be as gratefully acknowledged in the future as in the past.

Francis J. Spence
Archbishop of Kingston

***

This year of 1995, marking the one hundred and fiftieth anniversary of Hotel Dieu Kingston, is a year of grateful retrospection and joyful anticipation.

As we look back over the century and a half since the first three Sisters came from Montreal to begin their modest hospital in Kingston, we cannot help but marvel at the many instances when God's loving intervention has guided our venture "through many dangers, toils and snares.""his is evident from the support of the many "friends of Hotel Dieu," men and women of all walks of life who have stood by the Sisters in all their endeavours.

As we consider our present situation and the uncertainty of the years that lie ahead we can, with faith, expect the same guidance to enable us to carry out our mission into the next millennium.

It is my prayer that we may do so with hope-filled and joyful hearts, an inspiration to all who so faithfully collaborate with us.

Sister Elizabeth MacPherson, R.H.S.J.
Sister Liaison
Hotel Dieu Hospital

***

Celebrating the 150th Anniversary of the Hotel Dieu Hospital has given me a wonderful opportunity to consider thoughtfully the remarkable story of the Religious Hospitallers of Saint Joseph in Kingston. It is humbling indeed, to read about the countless individuals, both religious and lay, who played important roles in the history of the Hospital and to reflect on the innumerable events that have led up to this significant milestone.

The values and mission of the founding Sisters remain the touchstones by which we measure our success to-day —the foundation upon which all future endeavours of Hotel Dieu Hospital rest. The leadership, strength and caring abilities of the Religious Hospitallers of Saint Joseph are a rich heritage, and remain a strong influence on each and every one of us now, and in the important years ahead.

Hugh C. Graham
Executive Director
Hotel Dieu Hospital

***

As we celebrate the sesquicentennial of the Hotel Dieu Hospital in Kingston, I cannot help but reflect that the only constant in our world today is that we live with constant change.

How reassuring to know that, amidst this endless change, is an island of consistent values. While continually adapting to the demands of modern medicine, Hotel Dieu has maintained its values for over 150 years. Today, the Hotel Dieu Hospital is a modern, viable, Kingston landmark and a dedicated member of the Greater Kingston health care system, co-operating enthusiastically with all the health care givers in our community and in Eastern Ontario.

The Board of Directors acknowledges, with unabashed admiration, the Religious Hospitallers of St. Joseph who had the courage to start this journey 150 years ago. To their successors who have followed over the last century and a half, maintaining the mission, philosophy and values of the founding Sisters, we owe or deep gratitude.

As we celebrate 150 years of achievement, let us reflect back with admiration and pride, while looking ahead with confidence, because the journey has just begun.

Terry Stafford, Chairman
Board of Directors
Hotel Dieu Hospital

Hotel Dieu Hospital Kingston
The House of Tender Mercy: Continuing to Serve

The First Step

The history of the Hotel Dieu Hospital (HDH) in Kingston is an account of faith, hope and charity in the name of St. Joseph.

The first player in our tale was Jérôme Le Royer de la Dauversière, born on March 18, 1597 of an old Breton family, whose ancestors helped defend the Faith in the Crusades. Two centuries before either Pasteur or Florence Nightingale, although the wealthy were cared for in their own homes by servants, the sick poor depended on whatever charitable organization was prepared to help. On February 2, 1630, Jérôme received a vision in which God told him to establish an order of nursing sisters to care for the sick, poor and most needy, to be called the Religious Hospitallers of St. Joseph (RHSJ) in honour of the Holy Family. The new Order was canonically established in 1643. The title dates back to the Crusades, when "hospitaller" was the designation of an Order of military monks or knights who served as the military medical corps for the Christian forces trying to rescue the Holy Places from the hands of the "infidel".

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Jerome le Royer de la Dauversière (1597 - 1659), Founder of the Congregation of the Religious Hospitallers of St. Joseph.

Three wealthy young women were inspired to serve the sick in the little hospital that he founded in La Flèche, France: Marie de la Ferre, the daughter of an alderman of Baugé; Anne Foureau; and Anne de l'Epicier, a maid of honour to the Princess de Condi. They formed the first "Ladies Auxiliary."

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Mother Marie de la Ferre (1589 - 1652), Foundress of the Congregation of the Religious Hospitallers of St. Joseph.

Following the establishment of foundations in France, Jérôme's attention turned to the New World. The founding of Montreal was to be peaceful, but the difficulties were immense. The island, 180 miles upriver from Quebec and owned by a M. de Lauzon who was not willing to part with it, was uncolonized. In late 1639 Jérôme began recruiting settlers, who wanted a woman in the expedition to nurse any sick or wounded: Jeanne Mance, the second major player in our tale, who became the first lay nurse in North America.

Jérôme himself never went to the New World. Instead, he watched the two ships carrying the colonists and his dreams leave the port of La Rochelle at the end of May 1641, under the leadership of Paul de Chomedey de Maisonneuve. Six weeks

later, they arrived in Quebec, and in 1642 arrived at Ville-Marie, now Montreal, where Jeanne Mance established her hospital.

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Jeanne Mance (1606 - 1673), Co-foundress of the City of Montreal and Foundress of the Hotel Dieu of Montreal.

Two hundred years, however, were to pass before any new hospitals were founded by the Religious Hospitallers of St. Joseph in North America. Kingston's Hotel Dieu was the first "daughter house."

By the 1840s, Kingston needed a hospital desperately. At first, the Loyalist settlement was under military rule. Surgeons attached to the British regiments in the area provided the only professional medical care available. In fact, the first hospital in Ontario, except for a primitive hospital at Sainte-Marie-Among-the-Hurons, and one for Aboriginals at Sault Ste. Marie, was probably located in the military garrison in Kingston. The soldiers and sailors wounded in the War of 1812 were cared for in the three naval and military hospitals shown in the 1816 records.

There was little need at that time for a civilian hospital. The wealthy were cared for in their own homes. The few sick poor were cared for by the ladies of the Female Benevolent

Society, an ecumenical group which since 1819 had provided the only hospital care for the poor in Kingston. Concerned as much with poor relief as with medical care, they housed the sick first in old blockhouses and later in an empty brewery warehouse from November until the first of May. The shelter, overseen by a single matron hired by the Society, provided food, accommodation and minimal nursing care during the winter months. Such institutions relied on charity — the free services of volunteer groups and local doctors, poorly paid medical staff, and gifts of cash or goods, including leftovers from parties or social functions.

The small settlement of Kingston prospered with the increase of commerce on the Lake. When Irish labourers arrived in 1827 to work on the construction of the Rideau Canal, further strain was put on limited medical resources. A cholera epidemic a few years later exacerbated the situation. Kingston citizens lobbied for the construction of a hospital, finally completed in 1835; but during the next ten years this "hospital" was used first as a military barracks and then, during the two years (1841 to 1843) when Kingston was the capital of Canada, as the parliament buildings. The city now was a vibrant port on the Great Lakes system with a burgeoning population.

Unfortunately, poverty and a need for increased health care accompanied this growth. With the influx of Irish immigrants, Bishop Remigius Gaulin recognized the need for a Catholic hospital to provide care. In 1841 he begged Bishop Ignace Bourget of Montreal to send him Sisters to open such a hospital in Kingston. Bishop Bourget came to the city to investigate the call, and found the poor sick almost totally abandoned. On his return to Montreal he described what he had found, warning the Sisters of the difficulties of extreme poverty and the atmosphere of bigotry. "You must depend solely on Divine Providence," he said, but assured them that God had never failed those who placed their whole trust and confidence therein.

The Montreal community of Sisters was determined to help, and although their departure was delayed for four years they refused to unpack the many large bundles destined for Kingston. "If God wants us He will in His own good time remove all obstacles," said Sister Amable Bourbonnière. Help was to come from an unexpected source, once again a lay woman. Towards the end of 1844, Miss Josephine Perras from La Prairie on the south shore of the St. Lawrence River, did for Kingston

what Jeanne Mance had done for Montreal. She devoted herself and her fortune to establishing a hospital in Kingston.

Oil on canvas by Michael C. Walker. 1981 / Photo by The Bronson Agency

Sister Amable Bourbonnière (1793 - 1855), Religious Hospitaller of St. Joseph, Foundress of Hotel Dieu Hospital, Kingston, Ontario.

Sister Bourbonnière, the Kingston Foundress, took the steamer to Kingston on May 26, 1845, accompanied by Josephine Perras and Mr. Laframboise, a friend of the community. On their arrival at 4 p.m. on the evening of May 27, 1845, they were welcomed by Bishop Patrick Phelan, who had succeeded Bishop Gaulin, and by Vicar-General Angus Macdonell. The party was given warm hospitality by the Sisters of Notre Dame Convent, who had arrived in Kingston in 1841. Next day, Bishop Phelan bought property at the junction of Brock and Sydenham Streets: 229 Brock Street for use by the Sisters and for beds for four women; and 233 Brock Street to serve as the convent, novitiate and Chapel, for the sum of $3,000, the funds provided by Miss Perras. 233 Brock was about 35 x 30 feet, and 229 30 x 26 feet. One source says 229 Brock served as the Chapel until 1848 when 231 Brock was built. The present Chapel came into use in 1891.

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Miss Perras, with her lantern, searches for waifs, 1845.

In 1843 Dr. William Hallowell, a Quebec non-Catholic doctor resident in Kingston, had visited the Montreal cloister to assure the Sisters of his services for the proposed hospital free of charge to them and the poor sick. He became the first physician on staff, serving from 1845 to 1847.

Mother Bourbonnière, Miss Perras and Mr. Laframboise returned to Montreal on May 31, 1845. On June 24, the Montreal community held a second election for the Kingston mission. On September 1, 1845, Mother Bourbonnière, Superior of the new mission, accompanied by Sisters Louise Davignon, Huguette Claire Latour and Emilie Barbari, left for Kingston again, accompanied once more by Josephine Perras and Mr. Laframboise.

The group arrived the next day to be welcomed by Bishop Phelan. The Sisters spent the next two days as guests of the Notre Dame Sisters and on September 4 they moved under their own roof at 229 Brock Street, with help from Rev. Father Macdonell, Miss Perras and Mr. Laframboise. The next morning the Bishop, assisted by the Vicar-General, celebrated Mass in

the Hospital Chapel. Mr. Laframboise sang in a good tenor voice Veni Creator, imploring the aid of the Holy Spirit on this new venture. During Mass the little altar boy, wanting to surprise everyone, sang a little hymn faultlessly and without music. He later became a Jesuit, Father O'Shea.

The Chapel was so small it could contain only the altar and credence tables. The Sisters had to hear Mass from the adjoining room, and a kneeling bench was placed at the door for them to receive Holy Communion. After Mass each morning, the Chapel door was closed and the adjoining room used for a community room, parlour, pharmacy or sacristy, whichever need of the moment had to be met.

The Sisters welcomed their first patient, Mrs. James Delaney, on September 12, 1845.

Twice weekly in the Kingston Chronicle and Gazette, from October to December 1845, the following notice appeared:

NOTICE.

THE HOTEL DIEU, opposit the Catholic Seminary, Brock Street, is now open for the receptionof persons requiring Medical or Surgical assistance.

VISITING MEDICAL OFFICER, Dr. Hallowel.

CONSULTING do do Dr. Sampson.

N.B.--Visiting hour from 9 to 10 o'clock A.M.

Kingston, Sept. 16, 1845.

Kingston Chronicle and Gazette, 1 November 1845

The Sisters slept in a ward so small they bumped against each other while dressing. Without chairs, and with only two small stools, one for Mother Bourbonnière and the other for their benefactress Miss Perras, some sat on the floor and others on packing boxes. The flue did not vent properly and the rooms were often smoky. Food was poor and coarse.

On September 8 Mr. Laframboise and Father Blanchet left for Montreal. Before his departure, Mr. Laframboise sent a supply of provisions for the Sisters and the sick. Both Sister Davignon and Sister Barbari soon fell ill. Sister Davignon, no doubt because of the change in food, vomited almost continually,

while Sister Barbari strained her back muscles lifting a patient. Both were incapacitated for about three weeks.

On October 7 the first patient to die at HDH passed away at 1:30 in the morning. Since the disease was contagious, the Mother Superior felt that the body should be removed at once. With no stretcher or mortuary, the Sisters had to place the corpse on a door and carry it to a vacant house nearby. The temporary stretcher would not go through the doorway. They had to put the corpse on the ground and move the door in sideways, putting it across two chairs. Then the remains were returned to the stretcher. Early the next morning, two friends of the dead man arrived at the ward. Unable to find the remains and unable or unwilling to speak French, they became very rude, accusing the Sisters of not handling the body with respect. Finally, when the situation was explained, the unpleasantness was resolved.

Near the end of October the Sisters moved into 233 Brock, the larger of the two buildings. A small outside building, once used as an Inn, became a Chapel 15 1/2 x 25 feet, with a door and window opening on Brock Street as well as a window on each side. The large house the Sisters now occupied, the Convent, contained the sacristy, community room, novitiate and rectory on the main floor; a dormitory for the Sisters, an infirmary for sick Sisters and two small rooms for the Foundress on the second; in the attic, the novices' dormitory; and in the basement a large kitchen, pantry and cellar.

As soon as they moved, they converted 229 Brock into a hospital, with the women's ward upstairs and the men's on the main floor. Accommodations were so limited they often had to refuse patients.

It was difficult to carry sick women to their ward. One night, a stout old lady died. The Sisters wrapped her in a strong blanket. One took her head, another her feet, and a third lifted on the trunk. Since the stairs were extremely steep and the body bulky, the descent was recorded as being more rapid than graceful. They placed the body on the same door which had seen previous use, and carried the corpse through the mud and wet slushy snow in the cold, dark night. Mother Bourbonnière walked ahead, carrying the lantern. Sister Barbari and the servant girl each carried one end of the door, and Sister Latour kept the body from rolling off into the mud. By the time they reached

the Chapel for the dead, they were exhausted. But a covered passage would soon provide shelter for such errands.

On October 28 Bishop Phelan officiated at the dedication of the Hospital, Chapel and monastery, assisted by the Vicar-General and Rev. Fathers Dollard, Lalor, Begley and Murtagh. The 15-pound bell, given by a friend in Montreal at a cost of £5 and baptized "Mary Joseph Patrick", was blessed and rung for the first time. Much to the aural distress of the Sisters, all the witnesses wished to have their turn at ringing the bell. The £7 5 shillings 6 pence collected for the bell was used in the latter part of November to construct a covered passage between the Hospital and the mortuary Chapel, the "Glass Passage."

The following day, October 29, the first election of the Order in Kingston was held, with Mother Bourbonnière again confirmed as Superior to guide the community. Mass was celebrated for the first time early in November. The Chapel was filled by townspeople all anxious to see the Sisters. One evening during Benediction an embroidered silk scarf and the little hammer and silver gong were stolen. The Sisters teased the priest about being unable to see the thief entering silently, but he responded: "Absorbed in seeing the good God before me, how could I see the bad thief behind me."

It quickly became obvious that the labourers in the HDH vineyards were too few. The Superior, noted for her ointments that quickly cured skin ailments, was Pharmacienne, Mistress of Novices, and Deponsière (Treasurer), and was responsible for the overall operation of the Hospital. Sister Latour became Assistant Superior, Chief Hospitaller, Companion to the Pharmacienne, Admonitor of the Superior, Secretary of the Chapter and Overseer of the Orphanage. Sister Davignon was Bursar, Sacristan and Portress, and had charge of the Refectory. Sister Barbari was community and hospital cook, made shoes and candles, and looked after the laundry, the poultry yard, the bakery and the mortuary Chapel.

The greatest impediment to their work was lack of space. The building was not large enough to accommodate both their own requirements and those of a public hospital. Miss Perras related, "Our only regret was owing to our scant accommodations, often we were reluctantly obliged to turn a poor man from the door."

A Captain Hunter, secretary-treasurer of the Seamen's Association and President of the Sailors' Society, began a

fund-raising campaign for the more than $4,000 that the Vicar-General believed would be needed to enlarge and furnish the two small stone houses (which still stand between buildings known to the Sisters as the Sydenham and Brock Street Apartments, the two taller buildings which flank that original Hospital complex and were built later.) A call for subscriptions brought support from seamen, clergy and businessmen, and he himself donated $240. The Hospital was intended to contain a men's ward and a women's ward, and to treat the poor of all denominations. He was so successful that in 1847 the first wing of HDH, a three-storey building at 231 Brock Street, adjacent to the Sisters' establishment, was erected. Father Angus Macdonell, the first Chaplain and nephew of the first Bishop, Alexander Macdonell, gave a parcel of land 67 x 172 feet of land on which to build.

Funds for the day-to-day operation were provided by alms received from the people of Kingston and the Sisters in Montreal and France. On October 28, 1845 Mr. and Mrs. Daly of the British American Hotel sent furniture and brought food. Mrs. Roarke, wife of a prominent merchant, and Mrs. O'Connell, who kept the Mess House, gave money and sent food three or four times a week. In August 1846 a three-day bazaar was put on by Kingston women in Regiopolis College, today HDH's Sydenham wing, and netted $393 which collected interest at six percent.

The Sisters believed firmly that God helps those who help themselves, and the sale of bread delivered by hand cart and sold throughout the city from a small bakery built in 1848 also helped support the Hospital. The bakery used as many as 70 barrels of flour per month in this endeavour.

On March 14, 1846, Angela Brouellette from Old Quebec sought admission as a postulant. She died on Christmas Day 1864. On June 1, 1846, Lucy McDougal, daughter of a Kingston merchant, became the first Kingston postulant. She lived the religious life for 52 years, dying January 19, 1898 at 75. Others soon joined: Sisters Belanger, Dubuc, Magorian, Brady, Conroy, Hickey, Leahy and Murphy. During their novitiate, however, they were to face the horror of typhus, and one, Sister Magorian, was to lose her life.

Compassionate Care of the Needy

Famine victims in Ireland and Scotland during the winter of 1846 and spring of 1847 faced a desperate situation which was clearly known to Kingston residents. Reports of widespread disease in Ireland, including one in a Kingston newspaper, accompanied news of unprecedented immigration from Britain. But there was little if any movement in early 1847 to prepare for the possibility of typhus. Even though Kingston had survived widespread panic and death during the 1830s' cholera epidemics, improvements in public health measures were almost imperceptible.

A by-law requiring a Board of Health to be appointed annually from members of the City Council had passed in 1838, but the Board had met only once between 1842 and 1847 and it was normally concerned only with establishing a basic level of cleanliness in public places. Epidemiological knowledge was rudimentary at best. The concept of quarantine for those obviously ill had gained much support in the 1830s, but, although Kingston was bracing for a huge immigrant influx in 1847, there was little public discussion on the need for quarantine before the opening of the shipping season in June.

Possibly Kingstonians were reassured by the presence of two hospitals, but neither hospital was well established or clearly accepted at the time of the typhus epidemic. The general hospital, a seasonal hospital concerned with poor relief as much as caring for the sick, provided mainly palliative care. The expansion of HDH had not been completed. In the spring of 1847 the building was still under construction, and by July, the men's ward still lacked a roof.

Early in May, typhus arrived in Montreal at the quarantine station at Grosse Isle with the arrival of the first ships.

The Sisters were well aware of the Montreal epidemic. Their Order, along with others such as the Grey Nuns, was nursing both immigrants and townspeople who were falling ill. By early July, they heard that among those dying were nuns and priests who had been caring for the sick. However, that spring the focus in Kingston remained on those sick within HDH walls. The Sisters were, after all, a cloistered order. Without permission from the Bishop, the amount they could accomplish was limited, especially with their small 18-bed hospital still under construction.

Even by late June, a general meeting in the town to discuss the best methods of meeting the needs of the expected influx of immigrants was sparsely attended and accomplished little. The civic leaders in Kingston seemed to be dragging their heels in preparing for the arrival of large numbers of sick and dying immigrants.

However, some authorities were thinking ahead to the impending tragedy. In June, the Governor-General, Lord Elgin, warned all colonial ports to build or obtain hospitals or sheds. Corporations were also advised to appoint a Board of Health from their elected representatives with the responsibility of supplying bread and meat to needy immigrants for six days, and a physician to provide medical assistance. Kingston responded positively. The City reconstituted the Board of Health and authorized its members to make sanitary regulations. It acquired the general hospital building to house typhus victims.

Each week, from June until the shipping season ended, steamers carried thousands from the ports of Montreal and Quebec to Kingston wharves, many already ill and others carrying the disease, in ships that had become floating morgues. Anthony Hawke, the Kingston-based Emigrant Agent for Canada West, tried to send as many as possible on to Toronto and Hamilton. But many died in Kingston. Others remained as orphans or single-parent families, dependent, for the time being at least, on public and private support.

The effect on a town whose population was about 7,000 was profound. The influx of Irish immigrants, malnourished and sick, highlighted the social problems already in existence in Kingston, and had a lasting effect on the city's organization and institutions.

There seemed to be little impact, at least at first, on the development by civic authorities of the principles of public health. Nor did it trigger an immediate expansion of either HDH or the general hospital. A citizens' committee was established to work in conjunction with the Board of Health, but the primary purpose of the committee seemed to be to protect the property and business interests of its 21 members. The only firm objective reached was to acquire the wharf adjacent to a brewery about half a mile from the general hospital which was located, then as now, on Stuart Street just west of Arch Street. The town government planned to have as many steamers as possible dock

at this wharf rather than at the commercial wharves on Ontario Street further east.

Sheds were quickly erected on government land near Murney Tower to shelter the sick, and placards posted to ask for volunteers. Although still cloistered, the Sisters immediately offered their services. A "Protestant gentleman," possibly Thomas Kirkpatrick, Mayor and Chairman of the citizens' committee, accompanied Vicar-General Rev. Angus Macdonell, to ask Mother Bourbonnière if the Sisters could provide further help. Their unfinished Hospital was already overcrowded, as were the general hospital and numerous sheds along the waterfront. The fever was now so widespread that some patients were cared for in the fields.

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

RHSJ caring for typhus victims, Kingston waterfront, 1847.

Bishop Patrick Phelan listened to the pleas for help. In early July he granted permission for the Sisters to break cloister and care for the sick in the sheds and the general hospital. Records tell that the Sisters accepted this development with "joy". Mother Bourbonnière was the first to leave the cloister, accompanied by a young priest of the Cathedral staff, Rev. J.P. Naylon, who himself died a few days later from the disease. Every day, two or three Sisters took turns in visiting the sheds.

Although techniques such as bleeding may have been tried, in general treatment involved providing a basic standard of cleanliness, feeding those who could eat, and isolating the sick. Although the epidemiology of typhus was not clearly understood by doctors of the day, the treatment was reasonably sound since it helped prevent the spread of the disease-carrying lice. By July, neither the municipal nor the colonial government could effectively quarantine those who were ill, and the disease spread wildly into the town as well. There were just too many sick. In the summer and fall, at the height of the epidemic, many Kingstonians feared and rejected the immigrants because of the death and disease they brought to the city. In addition, they jeopardized the existing social structure. Roman Catholic immigrants threatened to tip the balance between the Protestants and Catholics. Contemporary newspaper reports, almost certainly exaggerated, told of sharp divisions between Catholic and Protestant members of the community. Although some division was evident, both the Sisters and the municipal authorities often became partners in treatment and intervention in the problems of dealing with a sick and greatly expanded population.

The need for providing for so many presented a financial burden. It was more than just the cost of caring for the sick. Many families were unable to support themselves. The orphans, widowed and single survivors of the epidemic became the "inmates" of two institutions — the orphans in the orphanage established by the Sisters and initially supported by municipal funds and Protestant churches; and Kingston's first permanent House of Industry.

The general hospital, also crammed with the sick and with an appalling death rate, itself became a health hazard. During the week of July 17, the hospital contained over 400 patients, with 153 new admissions and 53 deaths. During the week of July 31, 46 deaths were recorded, but with new admissions, by the end of the week the hospital contained 453. About a dozen patients a day were dying. Moans of misery coming from the hospital and adjoining shed could be heard by those walking past.

These patients, as well as those in HDH, were cared for by four of the Sisters working in rotation, with whatever help the Female Benevolent Society could provide. All the Sisters were ill with typhus at one point or another over the summer and fall. They asked for help from the Mother House in Montreal. Two

nuns from France answered the call, arriving in the fall of 1847. Two of the four doctors themselves became ill with typhus.

Finally, in the third week of July the Town Council asked the colonial government for help in establishing an immigrant quarantine on Garden Island. The Board of Health strongly supported the move of both sheds and hospital to the island to safeguard the townspeople, and planned a hospital and houses for physicians and clergy in empty buildings on a 55-acre site that had already been selected. The Board also urged that all ships be forced to disembark immigrants on the island, thus establishing a quarantine similar to that at Grosse Isle. The government was unwilling to commit the necessary money and in the end no quarantine was established. In fact, as a local newspaper pointed out, with typhus throughout the town it was already too late.

By early August the situation was acute. The unfinished Hotel Dieu was overflowing. Some of the Sisters, exhausted and sick themselves, had to sleep on the floor.

More sheds were built, and by September 1 immigrant sheds were now located at the general hospital, at the brewery wharf west of the hospital, and along Emily and King Streets near the band shell that currently stands on the waterfront. The shed on King Street measured 90 feet by 18 feet. Special constables restricted immigrants to the hospital buildings and the sheds near the docks and along the waterfront.

Tension in the town continued to build, culminating in August in a riot at the main dock following an argument between a steamer captain and a local priest, Father Bernard Higgins. The Father had tried to visit a dying immigrant who he thought was aboard the ship, and was verbally abused by the crew. The next morning the priest challenged the captain about his right to visit dying immigrants, and registered a complaint with the head constable at the Town Hall. A crowd gathered, angry with the apparent violation of the priest's rights, threw stones at the captain, and took possession of the steamer. The resulting scuffle brought out the full panoply of officialdom: the Mayor, members of the Board of Health, Vicar-General Macdonell, various members of the religious community, other steamer captains — and 50 members of the regiment stationed at Fort Henry.

Feelings against the lake steamers were already high. Local newspapers were indignantly reporting abysmal living conditions aboard the lake steamers, fully as dreadful as those on the ocean vessels. Some stories claimed that 1,000 were crowded

on the deck of one steamer. Both immigrants and Catholic townspeople were irate about the supposed rough handling of a priest who wanted to visit a dying man. The Mayor apparently tried to squelch any official investigation since the laying of charges could have caused more violence involving Catholics, Protestants and immigrants alike.

Other tensions were further exacerbated. Overtones of class conflict were evident when wealthy King Street residents brought a suit against the Town Hall and the Board of Health in the fall. They alleged that their health was endangered by the huge 90-foot containment shed built, they felt, too close to their homes.

The trial against the Town Council focused public attention on the question of rights: those of residents versus those of sick immigrants. Defence lawyers stressed humanitarian concerns and the charitable work of the Board of Health, while the prosecution claimed that the malevolent immigrants had no right to be sheltered so close to the homes of the plaintiffs. The Council was found guilty of creating a public nuisance. The entire Board of Health promptly resigned.

The Sisters, strangely, were not mentioned in newspaper reports, although they probably spent more time with the sick than did Board members.

By mid-October, Hawke, the Emigrant Agent, reported to the Provincial Secretary that all those immigrants who could be moved were being sent to surrounding towns, including Brockville, Cornwall, Prescott and Bytown (now Ottawa). Plans included winterizing the Kingston sheds, and the town was to become the colony's eastern centre for sick and indigent immigrants. Boards of Health in neighbouring towns were to be dissolved.

The numbers of immigrants were staggering, according to Hawke — 7,000 homeless left, even after settling two-thirds of those who had arrived.

By 1848, more than 1,200 had died in the hospitals and immigrant sheds, some Protestants among the overwhelming number of Catholics. An "Angel of the Resurrection" statue erected by Kingston's first Archbishop, J.V. Cleary, once looked down on the pit where the 1,200 victims, Protestants and Catholics alike, were buried. Today, an archaeological and historic sites plaque at the new location of the monument at the corner of

Kingscourt and Kirkpatrick Streets honours those who died, as well as the ladies of the Female Benevolent Society.

Sisters too had caught typhus. In a letter dated July 3, 1847 Bishop Phelan reported that Sister Magorian died, in her delirium asking to be taken back to the sheds where the sick were calling her. A simple white cross in St. Mary's cemetery marks Sister Magorian's grave.

The typhus epidemic had a significant impact on the Sisters. When they first arrived in 1845, their numbers and minimal facilities limited their impact on the Kingston community. Even during 1847, since HDH was still under construction, it was of little use as a hospital for the sick. However, because they had responded so readily and toiled so untiringly in the sheds and the general hospital, they established themselves as a vital part of the community. Most striking of all, the Sisters and the civic authorities had worked in concert in providing both health care and relief, an outstanding achievement for a small cloistered group of nuns who had arrived only two years earlier.

From the first days of HDH, the Sisters found that orphans as well as the sick desperately needed their care.

Child welfare in the early 19th century left much to be desired. Until 1858, when the Protestant orphanage was opened, the Sisters operated the only orphanage in Kingston. Following the dedication of HDH, the Chapel and the Monastery on October 28, 1845, the Sisters had set aside two wards for the care of the orphans brought to the Hospital by Miss Perras.

During the typhus epidemic, the Sisters were asked by the government to take care of orphans. The gathering of the children from the immigrant sheds had the financial support of the colonial government (about £1 per month per child) and moral support from Protestant churches.

Vicar-General Macdonell had a staircase made at the gable end of the "new hospital", and supplied the Sisters with a large kitchen stove and its utensils, two stoves, and some provisions including barley, rice and flour. The supplies were soon needed desperately. On Christmas Eve 1847, the Vicar-General arrived on their doorsteps with about 100 orphans and their bedding, dirty and full of vermin. Four nurses carried the smallest, including a baby who was only a few weeks old. Two of the nurses stayed to help, since most of the children were very young and only 15 could care for themselves. The children's parents had been among the immigrants who were sick and dead.

The orphanage register records only 70 children actually arriving on Christmas Eve, ranging in age from a few weeks to 20 years. Another 36 arrived on January 22, 1848. Sister Dupuis was charged with caring for the boys and Sister St. Joseph the girls. The Sisters were thus presented with a much larger responsibility in addition to the 10 orphan girls they were already caring for.

Initially the children were placed in the Hospital wards, spartan at best, the girls upstairs and the boys downstairs in a room near the kitchen where they would be working. A stove heated each room, furnished by one chair for the Sister and two barrels with two boards on top as a table. Walls still were not plastered, rough boards protected the staircase, and nails fastened the windows.

At first the children slept two to three to a bed; the Sisters could find only 30 cots, full of insects, enough for only about half the children. Since the only dishes the Sisters had were the 18 tin plates and mugs, spoons and cutlery of the patients, the children sat on the floor around the stove and were served their dinner on Christmas Eve 10 at a time, standing to eat at the trestle tables. The large wards were so filled with children, bundles of clothing and bed ticks that the Sisters had to walk on the clothes and bedding so as not to step on the children.

Community support, desperately needed, was quickly forthcoming. Townspeople provided cloth for clothing and bedding, and during the early part of 1848 townswomen arrived daily to help sew clothing. A Protestant minister's daughter, Miss Burnell, came to help, and her mother sent linen for bedding for the sick. Miss Burnell, along with other women, visited regularly and always left some money for the children. The Montreal Sisters too sent clothes, furniture, linen and funds. Finally, by January 7, the children had been properly clothed.

The Sisters' Annals indicate only two children died, one two months old and the other four years old; the register for the orphanage shows three deaths. Not all of the children were "orphans". According to the register, 50 of 106 children were reunited with a father, a mother, or both during 1848. A close family member such as an uncle or a sister claimed another six.

When government funds to support the orphanage began to run out by August 1848, Bishop Phelan directed the Sisters to try to find homes for those without families. An individual wanting a child would bring a note of recommendation from the

Bishop or from Vicar-General Macdonell. When they received the recommendation, the Sisters would line up the children. When those seeking a child had made their choice, the Sister would call out the name of the chosen one, and the heartbreaking farewells as children left their "home" and their friends were painful to watch.

By April 1849, except for five boys under the care of Sister Barbari in the kitchen, and 15 girls supervised by Sister Latour, all children had been placed, probably in farm or domestic service. Rev. John Farrell (who became Bishop of Hamilton on May 11, 1856) took up a collection to finish the two large wards which were then dedicated to the sick. He raised £80 ($320). But the third storey was still unfinished. After a severe smallpox epidemic swept the city in 1857, Kingston's women organized a bazaar which raised about $1,200 for renovations to the orphans' quarters.

Two orphans stayed with the Sisters for life. On January 25, 1917, the Sisters mourned the death of Joseph Lloyd, who had been found abandoned in the Tyendinaga Indian reserve 65 years earlier and brought by Bishop Phelan to the Sisters. He chose to remain with them, a faithful employee until his death.

In June 1961 Miss Tillie Hodgson, born in England and now retired, died at the age of 94. Tillie came to the Orphanage in 1867, Confederation Year, and for many years served in the kitchen. She was cared for by the Sisters on Brock 4 after she became ill. She became "trustee" of the linen cupboard on that floor, and used to sleep with the keys under her pillow at night. A cup of tea or some cinnamon toast would persuade her to relinquish the key so that the nurse on duty could make up the needed beds.

The Sisters were not the only Kingstonians concerned with the care of orphaned children. In 1856, the Female Benevolent Society, newly renamed the Widows' Friend and Orphans' Home Society and subsequently The Orphans' Home and Widows' Friend Society, purchased a frame building on Earl Street and built an extension on the building for a schoolroom and extra dormitory. The first residents of the Kingston Orphans' Home were 13 orphans from the House of Industry. An additional 70 children from destitute families were enrolled in the school. The Home received its Charter in 1862.

Still more children arrived in Kingston between 1888 and 1894. Catholic children in general were sent to the Catholic

orphanages, and the few Protestants to the Protestant. In general, the HDH orphanage sheltered girls, and the House of Providence boys. The HDH orphanage also received English Catholic orphans between 1884 and 1887. On the Feast of the Sacred Heart, 1889, the orphans, now numbering about 30, narrowly escaped injury or death when the ceiling of the orphanage suddenly gave way, destroying tables, chairs and cots. Fortunately, the children were having breakfast in another room at the time.

In May 1910 all the remaining children at the HDH orphanage joined the orphans from the House of Providence at the new St. Mary's Orphanage at St. Mary's of the Lake, opened by the Sisters of Providence of St. Vincent de Paul. The site is now that of St. Mary's of the Lake Rehabilitative Hospital.

The work of the Religious Hospitallers of St. Joseph, the Sisters of Providence, and the women of the Female Benevolent Society under its different incarnations, has resulted in a very large number of the social and health services taken for granted in Kingston today.

THE FIRST HOSPITAL BUILDING

The Sisters endured yet another alarm in that first hospital building. In December 1847 at about 7 p.m. Sister Dupuis discovered that the chimney of the men's ward had caught fire. A postulant, Sister Clemence, was sent across the road to Regiopolis College to ask for help. All the young men of the College came to their assistance immediately, climbing over boards and beams on the unfinished third floor, through the end window and up on the roof of the small house to reach the chimney of the sick wards. The students were able to put out the fire, but the Sisters were afraid that the fire had spread into the closed-up garret of the house where it couldn't be seen. With great difficulty Rev. Mr. Chisholm pushed his head through a small hole in the ceiling to check for sparks, and fortunately found none. Without a ladder or bench to use to get down, he clambered down on some shelves holding linens. Shelves, linens, and Rev. Mr. Chisholm all arrived on the floor together, fortunately without injury.

Work in the Hospital was becoming more and more arduous and the Sisters prayed for St. Joseph to send them more help. That same evening in March 1846, the Kingston stagecoach stopped in front of their door. The portress who answered the bell was greeted by Sister Louise Prefontaine with the words, "Well, Sister, here I am, a substantial answer to your prayers."

After three years as Superior, Mother Bourbonnière was forced to resign because of ill health, to be succeeded by Mother Louni in 1848 and then by Mother Latour, one of the first arrivals. Mother Bourbonnière died, in Montreal on March 18, 1855.

The Queen's Medical School opened in 1854 and made use of the limited HDH facilities for the instruction of medical students, an omen of the Hospital's ultimate heavy involvement in teaching.

Although HDH had been established for 12 years, on Bishop Edward Horan's first visit in 1857 he was struck by the extreme poverty. He suggested that the Sisters would be much better off financially and otherwise if they were not enclosed. Although he offered to write Pope Pius IX to request a

dispensation from enclosure, he was disappointed to find that the Sisters wished to remain faithful to their vows of enclosure.

In 1863, an epidemic of smallpox struck the city. Some of the orphans being cared for by the Sisters contracted the disease, as did the postulant Sister Elizabeth Norris. Fortunately, all recovered. The same year, the Montreal Sisters departed, leaving the Foundation in the hands of Sisters Monica Brady, Margaret Hickey, Jane Leahy, Lucy McDougal and Julia O'Brien. On March 4, 1868, HDH received official recognition. The Ontario legislature passed an Act of Incorporation of Hotel Dieu Kingston, which listed Sister O'Brien as Superior.

In 1865, a group of men under the leadership of Dr. Michael Sullivan, a Queen's graduate, the Sisters' physician and lifelong friend and supporter, formed a committee, the forerunner to the Board of Directors, to look at ways and means of building another wing.

The Sisters had been contemplating building a hospital and monastery for some time, urged by Dr. Sullivan who stated that unsanitary living conditions were causing the deaths of too many Sisters. In the past few years they had lost six young Sisters. Mrs. Ellen Hickey, mother of Sister Hickey, promised Bishop Horan that if he would buy 12 acres of land near the Cathedral in the area of Sydenham and Clergy, she would help pay for it. The Bishop purchased the 12 acres at $400 per acre, payable in 12 years at six percent interest, and Mrs. Hickey promptly paid the first instalment. However, the Bishop would not permit the Sisters to begin the Foundation, claiming that other diocesan matters were claiming his attention. Even after a deputation including the chaplain Jacques Lonergan and a number of prominent Catholic laymen met with the Bishop in March 1867, asking that the Sisters be given possession of the deeds for the property, the Bishop would not agree. "Monastic property," he stated, "should be in the possession of the Ecclesiastics, not that of the Sisters or laymen."

The proposed building of the Hospital came to a complete stop, since the laymen on whom the Sisters were largely dependent for aid were unwilling to invest their money in a building which might be taken at any moment for church property or to pay church debts. Such problems however, were finally overcome. Dr. Sullivan and other friends organized a fund-raising bazaar and raffle and raised $1,600, while the ladies of the city held a Fancy Dress Ball which brought in $333. The addition, a

new wing begun on May 31, 1872, was dedicated by Bishop Edward Horan later that year. Its addition to the early Hospital complex of 229-231-233 Brock Street resulted in HDH becoming probably Kingston's first high-rise. That wing at 235 Brock Street, known as the Brock Street Apartments, still stands.

In February 1875, about 10 days after the death of Bishop Horan, Vicar-General Macdonell died at the age of 76. He had been one of the greatest benefactors of the House, giving the grounds on which the Hospital is built and the ground opposite Regiopolis College known as the Vicar's Field (the area bounded by Clergy, Johnson, Sydenham and Brock with the exception of St. Mary's School. In 1887 part of the area was used as a playground by the orphans).

The new year of 1890 was ushered in by illness, 15 of the Sisters falling victim to influenza. Three and sometimes four Sister Infirmarians were in constant attendance. The priests also fell ill, and the Sisters were deprived of spiritual comfort as well. Fortunately, by May all had returned to normal.

Sister St. Michael (Florence Morton), interviewed in 1963 when she had been associated with HDH for 66 years (she died in June 1971 at the age of 90), remembered when the Hospital area and the community's living quarters were separated only by a rod with a curtain strung across it. Sometimes in the night the old and chronically ill patients who could not sleep would wander over into the Sisters' sleeping quarters and would have to be led back.

The Hospital at the turn of the century could hold approximately 80 patients in two large men's wards, St. Benedict's and St. Joseph's, with two private rooms, St. Roch's and St. John of God. There was one large women's ward with only one private room. The staff of about 50 Sisters did the work for the whole Hospital — nursing, housekeeping, business management, cooking, laundry. (In 1972 there were only 14 Sisters but 1,200 staff.) Hospital finances of the time were very strained. Bed linen was in short supply, and the laundry had to be done each night to have enough for the next morning. They would do a full day's nursing which often included rinsing the stained bed linen before it went to the laundry; and then, because of the extreme shortage of nursing staff, would have to volunteer to go right back on the night shift.

Born in 1872, Mr. Timothy J. Rigney, who served at times as legal counsel for the Hospital, remembered as a small

boy living on Johnson Street when HDH had not yet moved to the Regiopolis College building. That building had been standing empty for years, a hollow shell with a great long open shed for garden tools. It was surrounded by gardens and orchards and was, with the Bishop's garden, under the care of one old man, Mickey Loftus, and his wife. The bane of his life was the small boys of the neighbourhood - and Mr. Rigney was one. They used to divide into two troops, one to raid the orchard from Johnson Street and the other to break in from Brock Street. Poor Mickey could only go after one troop at a time and meanwhile the other troop would gather enough fruit for all.

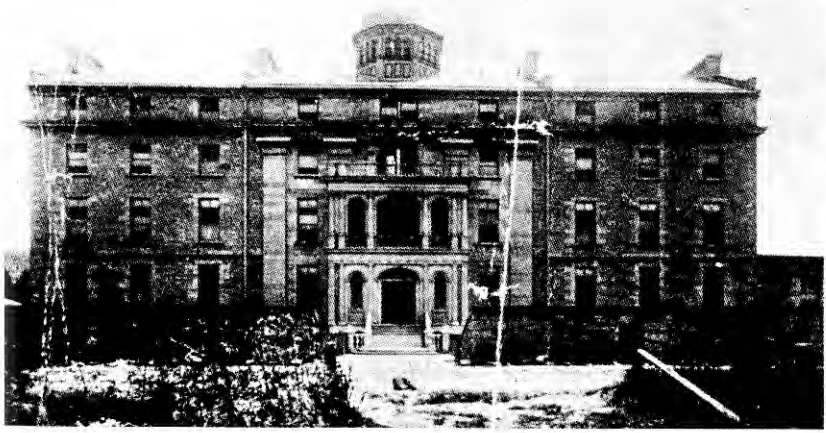
Mr. Rigney remembered that the Sisters built a plank fence around the gardens which extended from Sydenham to Bagot. They grew potatoes, celery, carrots, asparagus, apples, grapes and currants, and kept chickens and cows for eggs and milk. The gangs of boys had a harder time getting in to raid, but sometimes were able to remove a plank if the gardener did not scare them off with rocks or his Irish shillelagh. At that time there were no houses at all between Sydenham and Clergy Streets. The area was known as the Brothers' Field and the only building was the small Brothers' School at one end of it. Mr. Rigney's uncle kept race horses and used this field as an exercise ground for his horses. During the winter a group of sailors would set it up as a skating rink and an open air curling rink.

THE "REGI" HOTEL DIEU -
NOW THE SYDENHAM STREET WING

By 1890, it was obvious that the site of 45 years was too small. Archbishop James Vincent Cleary, appointed Bishop of Kingston on April 7, 1881 to succeed Bishop John O'Brien, advised the Sisters that the Regiopolis College building, built in 1837, would soon be available. The Sisters reluctantly decided to purchase it and its grounds, which occupied a whole city block, for $60,000. The Bishop promised to renovate the staircases, open up a new drain, and provide $10,000 to help build the church. Because of the terms of the will of Bishop Macdonell the Sisters could not be given the deed for the property, but could lease it for 99 years, paying $2,500 and a rental of $1,250 per year. Acquisition of the College building was completed in 1891, and by January 1892 the transfer to the new quarters took place after alterations. The building was five stories high with a large

dome. Entering off Sydenham Street, the visitor passed through a 26 x 10 foot portico two stories high resting on moulded stone piers with large fluted columns, carved capitals, and ornamental stonework. The floor of the vestibule was inlaid with variegated patterned tile and the walls and ceiling panelled. Oak panelling, bevelled plate glass panels and carved oak doors all lent an aura of magnificence.

The Hospital's renovations, designed by William Newlands of Kingston, were highly praised. It was claimed that the equipment and workmanship made it one of the finest hospitals on the continent. There was even room for the Sisters' dormitory on the third floor, a community room and an infirmary.



Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Hotel Dieu Hospital, Sydenham entrance, circa 1900.

Furthermore, the Regiopolis College Committee gave $10,000 toward the building fund, and the Archbishop $5,000, a bell, and bells for the wards and private rooms.

Unfortunately the renovations were not without tragedy. On June 20, 1894 one of the workmen fell about 45 feet and a 300 pound stone toppled on him, crushing him. He was carried to the Hospital and lived long enough to receive Absolution and Anointing.

Even after the renovation, Hospital facilities continued to expand. In May 1899, a surgical theatre, completely modern for the time, was built at the northwest corner of the main Hospital, at the corner of Johnson and Sydenham Streets. (It was demolished and replaced by the Centenary wing which opened in 1950.)

By 1910 it was becoming obvious that the Sisters could no longer provide all the Hospital staff, and this triggered the formation of St. Joseph's School of Nursing. It opened in September 1912 with Sister St. Charles (Louise O'Connor) as Superintendent. Its history is related in another chapter.

In 1915, an outbreak of typhoid in Kingston coincided with a great shortage of nurses. Student nurse Margaret Mary O'Keefe, who later became Sister St. Oswald, had 18 cases under her care. She worked 12 hours a day taking temperatures and pulses, keeping charts, giving medicine and food, washing patients and preparing ice packs for those with a fever over 102 degrees. She had to watch them all, as many were delirious and apt to harm themselves. The students were constantly reminded of the great need for personal cleanliness to protect themselves from contagion. One Sister caught typhoid pneumonia while working on the night shift, and died of the disease.

In August 1916 a great many repairs were made to the main building on Sydenham Street. The main entrance was marble tiled and the corridors laid with rubber matting. Walls of the corridors were repainted, woodwork varnished, white mounted baths and sinks positioned on every floor, and an electric light system was installed in the main halls and corridors.

In 1918 the Spanish influenza struck Kingston, a disease with a very high toxicity, and characterized by extremely high fever. HDH was once again crowded with epidemic victims, and Sister Mary Duffy, who contracted the disease, died. Dr. J.P. Quigley remembered a young woman admitted one night who was visited by her anxious husband. The next evening the husband was also admitted, and both were dead before morning. Many patients were lost from the pneumonia resulting from the disease. Eighteen Sisters and 22 nurses, as well as many on the wards, were affected, Sister St. Michael among them. She and Sister Tierney (who had come to HDH in 1913) remembered the many young people brought to the Hospital in advanced stages, often turning blue and dying within a few hours. City women

were called in to help because the numbers of sick exceeded the nursing capacity of the Hospital staff.

Sister St. Michael was in the original nursing class of 1912, when nursing was taught at the bedside rather than in classrooms. She recalled the days of World War I when Dr. Gordon Mylks Sr. and Dr. Edward Ryan were in charge of a ward for soldiers needing treatment before going overseas, how very young the soldiers were, and how sad it was to think of them as fighting men.

After the War the Hospital had a number of pensioners as boarders, the badly injured and shell-shocked cases who could not be sent home. Some were in such a pitiable state they could not be left alone.

In the 1920s, areas of the Hospital were named after saints. Brock wing corridors were named St. Anthony's (5), St. Margaret's (4), St. Joseph (3), and St. Michael's (2). In the Sydenham wing, the large wards were also named: St. Anne's (5); St. Bridget's, the Holy Family and the Blessed Virgin (4); St. Benedict's, St. John of God, St. Roche's, St. Patrick's, and St. Aloysius (3). The practice was continued until the Johnson wing was opened in the mid-1960s.

The Sisters were called upon unexpectedly to accept some military patients when, on January 3, 1923, the Sydenham Military Hospital burned to the ground. St. Benedict's ward of 12 beds was filled, St. Roche's of five, and still more room was needed.

By December 4, 1927, more improvements were completed. The wards were divided into smaller wards, with a solarium or sunporch facing east on the three top floors. Cement or tile floors were installed in bath and utility rooms, and old electric fixtures replaced. The main entrance, pharmacy and main office were tiled with ceramic tile. The Information Bureau was moved near the entrance door, and a record room installed on Sydenham 2, although the first indication of medical records did not appear until 1930, when Sister Florence Campion, a Director of the School of Nursing in the pre-1920s, established a medical record system. Cost of the renovations was about $16,000.

The world continued to change. On June 4, 1929, the first airmail service to Kingston was inaugurated, and in the same year Canadian women legally became "persons".

In 1937 more renovations on the main entrance were completed. The parlour opposite the elevator was made smaller

with a lobby to give privacy to patients being admitted. A dining room for female help was opened on December 19, 1937. The old pantry, part of the Hospital kitchen, was made over, and the former dining room renovated for canning and preserving, and storing fruit. On April 2, 1940, a new elevator was completed and the main entrance of the Hospital remodelled and painted. A new fire alarm system was installed in the Hospital and the monastery in April 1942. The Hospital now had its own private line to No. 7 fire station. The same year a blood bank was installed, thanks to the Ladies Auxiliary and the Knights of Columbus. In August 1944 a painting of Jeanne Mance was purchased for the main entrance, using a donation from Dr. Walter Gravelle, brother of Sister Elizabeth Gravelle.

On July 30, 1945, the Hospital took part in the parade of floats with Kingston General Hospital (KGH) and the Ontario Hospital in honour of the Centenary of the incorporation of the City of Kingston. The float depicted Jeanne Mance introducing the Religious Hospitallers of St. Joseph into Canada, as well as a scene showing conditions in 1845 when the Hospital was established in Kingston.

On September 11, 1945, a three-day observance of HDH's 100th anniversary began with a Solemn Pontifical Mass by Archbishop O'Sullivan. A letter from the Pope conveyed a special Apostolic Blessing, and a civic banquet paid tribute to the Sisters' accomplishments. Other celebrations included Pontifical Low Mass, luncheons by the Sisters for the Ladies Auxiliary and for the graduates and student nurses, a public reception and tea, and a banquet for the medical staff and doctors. A Pontifical Benediction was followed by a reception for religious visitors and a cantata staged by music students of the Sisters of Providence, telling the story of those who contributed to the 100 years of progress.

In October 1948, to enhance further the clinical teaching program at Queen's Medical School, the Sisters decided to close some wards to meet the requirement for clinical teaching units. On March 10, 1949, fireproofing work began on the main building adjoining Centenary wing. The ice plant and cold storage had to be moved nearer the main kitchen. In 1952 work began on the nurses' dining room, partially financed by the Ladies Auxiliary. The modern cafeteria opened in 1954 for interns, nurses (graduate and student) and employees. Between 1953 and 1954 renovations also took place in the Admitting Office,

and the J.B. Bickel Foundation donated $30,000 to build a new operating room. In 1960, St. Joseph's Corridor became officially the medical floor. St. Margaret's Corridor was already the surgical floor.

Between 1950 and 1962, when Sydenham wing was declared a fire hazard, Hotel Dieu had 319 beds and 42 bassinets. The resulting exacerbation of the space crunch triggered a major fundraising campaign which led to the building of the Johnson wing. Still more renovations in 1962 saw the Blessed Virgin Ward on the women's floor become the Medical Library, and three rooms were amalgamated to form one large conference room. The former kitchen on Sydenham 4 was transformed into the first coffee shop. The Sydenham Street entrance received a face-lift in 1979; and in early January 1980 the Pastoral Care Office and Clergy Room were made available on Sydenham 2 after Purchasing moved into the vacated Nursing office.

Construction in 1986 included repairs to the old Sydenham entrance and installation of the mechanical rotating door in the main entrance of the Jeanne Mance lobby. The Sisters hoped in 1987 to restore to its original state the second storey of the Sydenham entrance.

Today, Sydenham 1 serves as storage space, Sydenham 2 houses the finance department, Sydenham 3 contains physicians' offices as well as the Child Life program, Sydenham 4 also houses physicians' offices and provides library space, and Sydenham 5 contains not only the fitness area but the human resources department. The Sydenham wing has now been declared a heritage site.

A hospital is a living organism. It grows, ages, transforms. Sections are demolished, others erected.

A speeded-up overview of the Hotel Dieu complex would reveal a constant, almost exploding growth, and internal ebbs and flows as departments are born, grow, and in some cases vanish. They move from space to space and wing to wing, responding to the needs of patients and the ever more complex medical technology. This history now departs from a specifically chronological order. The stories of individual wings will be told in sections devoted to each wing towards the end of the chapter. The overall general history of the

Hospital will pick up at the point of the move to the old Regiopolis College into the site now known as the Sydenham Street wing and the building of the Brock wing in 1909 — the first major expansion. St. Joseph's extension opened in 1931, the DVA wing in 1945, Centenary in 1950, Johnson in 1966, the Family Medicine Centre in 1976, the Murray building in 1981, and finally the Jeanne Mance wing in 1984.

CHAPEL - THE HEART OF THE HOSPITAL

That first large hospital in the old Regiopolis College building lacked an appropriate Chapel, and in March 1894 Archbishop Cleary promised to build one. On May 30, 1894 he laid the cornerstone of a new Chapel of St. Joseph, with 38 priests and more than 40 acolytes attending. The Chapel was completed in 1894, and the first Mass celebrated by Archbishop Cleary on March 1, 1895. At Christmas 1895, for the first time in the history of the House, Midnight Mass was celebrated by Rev. T.A. Kelly.

Donations flowed in to help complete the Chapel. Mrs. Davis, Father Davis' mother, presented the oak altar. Mrs. Michael Walsh gave the sanctuary lamp, and Mr. and Mrs. John O'Shea oil paintings for the Stations of the Cross. Mrs. Thomas Ronan presented a large electrical chandelier, and Mrs. John Halligan the sanctuary carpet. However, it was not until November 18, 1904, that the Chapel's stained glass windows were finally put in place. In February 1897 Mrs. Davis died, and Father Davis celebrated her Requiem Mass the second morning after her death. She was the first to repose before the altar she had presented the previous year.

The beginning of a new century was marked by the fitting of the Hotel Dieu Bell, christened "Mary, Joseph, Charles", a gift of Archbishop Cleary. It was blessed by Archbishop Gauthier on March 25, 1900, the Feast of the Annunciation, and replaced the modest bell "Mary, Joseph, Patrick" blessed by Bishop Phelan in 1845. The bell first given by Archbishop Cleary was too large for the belfry and was given to the Church of the Good Thief in Portsmouth. After his death, the Archbishop's executors presented the new bell. (It is now in the garden of the Provincial House in Amherstview.)

On May 12, 1918, following redecoration, the Chapel was reopened. It was now in the Italian Renaissance style in white, cream, buff and gold, thanks to a donation by Mrs. Katharine Warnock, a sister to the Founder of St. Bernard's Hotel Dieu in Chicago, Father Bernard Murray. In 1933, stained glass windows were installed in the Sisters' Choir in September, and the Stations of the Cross erected in October. On March 1, 1944, about $2,900 worth of cleaning and painting in the Chapel was begun. A new Confessional was obtained, and the Ladies Auxiliary donated new pews, costing $1,379.80 in all. A new floor was also to be installed at a cost of $1,384.20. In July 1945, at a cost of $3,000, a pipe organ had been installed, and in August new furniture was added and new lighting installed in the recently renovated Chapel. In October 1958 a gold altar curtain and a wrought iron crucifix with bronze corpus placed in the centre were hung and a new Baldwin organ installed. The Chapel was closed in 1964 for major renovations, and a room in the convent converted into a temporary Chapel. Younger Sisters attended Mass at Notre Dame Convent.

A new era in ecumenical relations began when a Chapel for Protestant patients opened in St. Roch's room on Sydenham 3 on November 11, 1967. (St. Roch's room had seen many uses over the years, including usage as a classroom in Regiopolis days.) St. Luke's Chapel was later moved to the renovated Sydenham 3 chapel gallery. On October 18, 1971 the first ecumenical memorial service in the Chapel was held, arranged by the Pastoral Care department in memory of all those who died in the Hospital, and of deceased relatives of Hospital staff. Participating clergy represented Catholic, Anglican, and United Church. This service became an annual event.

Repairs and renovations continued to be needed. On January 25, 1972 at 9.23 am, 50-mile-per-hour winds from Lake Ontario blew down about one-quarter of the stone wall appended to the old monastery wall of the Chapel. Age was taking its toll, too. On the evening of May 29, 1991, a large portion of plaster fell from the Chapel ceiling, damaging three front pews. Fortunately the Chapel was empty at the time. It was closed for repairs, not to reopen until September 29. Shortly afterwards, renovations costing $96,436, funded through an estate donation, included new carpeting, refurbished pews and a redesigned entrance for better accessibility for the physically-

challenged. The Chapel was reopened and officially re-dedicated on Friday, March 26, 1993 by Archbishop Francis J. Spence.

The Chapel's stained glass windows have been given over the years, many in memory of relatives of Sisters. The imposing round window facing the door is called "The Death of St. Joseph." It is flanked by two large windows, one honouring the Immaculate Conception of Mary, the Mother of God, and the other the Sacred Heart of Jesus.

Other Chapel windows depict the Flight into Egypt, St. Charles Borromeo, St. Vincent de Paul, Our Lord's Agony in the Garden, the Resurrection of Jesus from the Tomb, St. Margaret of Scotland, Jesus Blessing the Little Children, and Jesus Blessing the Sick (this window donated by HDH's Catholic medical staff).

Unfortunately eight round windows, four on each side of the Chapel, were hidden by plaster when the Chapel was redecorated following the directives of Vatican II. On the right hand side of the Chapel at the upper end, a large painting may also be hidden. The painting showed the Congregation's founder, Jérôme Le Royer de la Dauversière, at the moment that he felt compelled to establish the new religious Order. Records indicate the painting was done in 1918 when the Chapel was decorated for the 75th Anniversary.

As part of the 150th anniversary celebrations of the Hospital in 1995, organizers have planned to recognize the 100th anniversary of the first Mass in the Chapel with the installation of 14 new Stations of the Cross for the Chapel walls, carved by Jacques Bourgault, a member of a famous wood-carving family in St-Jean-Port-Joli, Quebec, to replace those installed in 1965 and removed during the recent renovations. Nursing alumnae, medical staff, employees and several individuals have sponsored the purchase.

Photo by Preston Schiedel

The Most Reverend Francis J. Spence, Archbishop of Kingston, blessing new stations of the cross in the Chapel on May 1, 1995.

THE FIRST ADDITION - THE BROCK STREET WING

Archbishop Gauthier, who succeeded Archbishop Cleary in 1898, performed the honours for the new five-storey Brock Street wing in October 1909. It was intended to provide private accommodation for patients, a lab, x-ray and clinical facilities, as well as eye, ear, nose and throat operating rooms on the second floor. The new wing housed private and semi-private rooms, bathrooms, a diet kitchen, a library or chart room, linen rooms and storage rooms. A sign of the times, telephones, electric lights and bells were installed conveniently on each corridor and hall. It boasted an outside spiral fire escape stretching from the fifth floor to the ground floor. Hospital legend recounts the June morning when an alcoholic, trying to leave the premises, raced down the stairs with Sister Morton in hot pursuit, trying to catch the tail of his nightshirt. He managed to escape through the gate, leaving the Sister standing helplessly inside the cloistered enclosure.

St. Joseph's Wing

The Hospital continued to expand. The first sod for another wing was broken on April 17, 1929, and on October 10 Archbishop M.J. O'Brien laid the cornerstone for the St. Joseph's addition to the Brock Street wing. Unfortunately, the new wing eliminated that unique outside spiral fire escape at the end of the Brock wing.

The St. Joseph's wing opened in 1931. The ground floor housed an outpatient department, an enlarged x-ray department, and the cardiology, urology and dental departments. At the east end of the corridor was space for a classroom and an office for the Instructress of Nursing. The second, third and fourth floors contained private rooms and a large solarium at the end of each corridor. Operating rooms took up most of the fifth floor, replacing the operating theatre on the third floor at the corner of Johnson and Sydenham Streets. The suite included operating rooms, a scrub room, a utility room, a workroom and an office.

On the street side, just inside the new wing, was a suite which included a waiting room, office, treatment room and operating room for eye, ear, nose and throat treatment. Across the hall were private rooms originally intended for eye, ear, nose and throat patients, but later part of the maternity department. At the same time, a new diet kitchen was installed on the ground floor between the Brock and residence wings. The Statue of St. Joseph and Child, a gift of Miss Irene Barrett, was placed on top of the new private pavilion on September 12, 1930. In 1982 it was placed on the ground in front of the Sydenham wing.

In the early 1960s, with the renaming of wards and corridors once called by saints' names, to the more prosaic labelling by wing, the name of St. Joseph for the extension to the Brock wing continued to exist only on some internal documents, and the entire Brock-St. Joseph wing became the Brock wing.

At times it sheltered more than just patients. Sister Audrey Mantle still remembers wheeling a patient down the corridor in the corner between Brock and Sydenham one night in the early 1940s and encountering a bat that knocked her nurse's cap off.

In March 1969 a $250,000 renovation to the Brock wing was announced, following the November 1967 fire described later in the book. Brock 4 by 1974 was under renovation, in the area built in 1909; and in January 1976 Brock 3 became the

orthopaedic unit. In November 1978 Brocks 3 and 4 were vacated for renovations. The Nursing Office moved to five rooms renovated on Brock 3, and the Pastoral Service to its office on the same floor. From 1972 to 1978 it had been located in the family room, which had served as a combined office and family room. The vacated nursing office became the area for the Administrator of Patient Care. Dating back to 1837, this area had served as the Bishop's parlour and dining area from 1892 to 1945. From 1945 to 1950 it saw service as the pharmacy, from 1950 to 1963 as the Board Room, and from 1963 to 1978 as the Nursing Office.

Today, Brock 1 houses medical records and adult outpatients, Brock 2 Cardiology and diagnostics, Brock 3 physicians' offices, Brock 4 laboratories and offices for the gastrointestinal team, and Brock 5 psychiatry offices.

NURSES' RESIDENCE

Although student nurses at first lived in the Hospital, Archbishop Spratt laid the cornerstone for the first free-standing nurses' residence in 1923. The first sod was turned for a temporary nurses' home on April 10, 1923. It would serve as a sacristy as well until funds for a permanent nurses' home were raised. On May 19, 1926, two storeys were added, which accommodated about 50 nurses, and two large rooms for the sacristy and an assembly room, St. Joseph's Hall, for the nurses and the Ladies Auxiliary. The residence later became temporary accommodation for interns, and subsequently the Sisters' residence.

On August 2, 1947, a $700,000 expansion program began a new two-storey nurses' home, the future Jeanne Mance Residence, facing Brock Street, with provision for three future floors. On September 12, 1948 the first two floors opened, providing dormitory space for first-year students on the first floor and classrooms on the second floor. The old classroom became an outpatient clinic. On March 23, 1955 the students moved from the ground floor to the completed third floor of the Jeanne Mance Residence so that renovations could be made, and on May 29, the Residence opened officially. It was later torn down, after the move of the nursing school to St. Lawrence College, to provide room for the new Jeanne Mance wing.

LOURDES GROTTO

In June 1924 the Grotto of Our Lady of Lourdes was completed, designed by one of the Sisters and constructed in thanksgiving for securing a home for the nurses. The Statuary was a gift of Mrs. K.M. Warnock. In its base were concealed several authentic relics and a phial of water from the original fountain in Lourdes, France. On February 10, 1963 this landmark was demolished.

INTERNS' RESIDENCE

At first, interns lived in the Hospital, but in October 1943 Dr. C.A. Howard's home at 199 Brock Street was purchased for $7,800 for use as a residence. It was renovated and ready for occupancy by January 6, 1944, and the first intern moved in on January 10. By 1956, seven were living in the Brock Street residence, seven in the Hospital and two in their own quarters. However, with the needs of a teaching hospital to be met, accommodation would soon be needed for at least 20. One possibility was the old nurses' residence; and in early 1957 renovations to the top three floors at an estimated cost of $2,764.30 were approved. They were completed by May 1, 1957, and came in slightly under budget.

This was a temporary measure only, and after considering two other possibilities, on April 15, 1958 the Board approved the purchase of the F.D. O'Connor house at 176 Johnson Street, which had land available for possible future expansion. On June 15, 1959 the new Interns' Residence officially opened. Soon, however, the interns moved into their own housing in the city, with beds available in the Hospital in the Mary Alice wing for those working at night. The F.D. O'Connor house was finally transformed into the Geaganano Residence for Cree patients and their families, opening in September 1985.

DVA WING

During the Second World War, St. Joseph's corridor and even the Solarium became soldiers' floors. When the war ended, beds were needed for assessment of returning soldiers and for any surgery needed as a follow-up for the emergency surgery performed in field hospitals. The Sisters promised the

Government that, if $75,000 was made available, they would provide 50 beds. In October 1945, however, they accepted a government grant of $50,000 to provide those 50 beds. The DVA wing was added behind the Sydenham wing. The old wooden balconies overlooking the garden that had been used for tuberculosis patients were removed. Three small units were built, consisting of two large wards and a three-bed semi-private room for the more seriously ill, as well as a kitchen, utility room, nurses' station and record area. The building was completely fireproofed with all modern improvements, terrazzo and tile on some floors and battleship linoleum on others, and up-to-date equipment.

The first of the two DVA wards (regulated by the Department of Veterans' Affairs) opened in 1945, administered by Sister Margaret Breault. On June 1, 1947, the soldiers' wing was completed, and the soldiers enjoyed the building with its modern conveniences. Reading material, games, etc., were furnished by the Red Cross Society. Also on June 1, the nursery on the top floor was blessed and opened by the Archbishop. It contained 32 cubicles, sterilizer for formula, exercise room, and room for premature babies. One inspector called it the most up-to-date in Canada.

By 1963, however, the DVA wards as such no longer existed. The second, third and fourth floors were amalgamated to provide one large nursing unit on each floor. In 1974 the DVA wards housed the Surgical and Medical Intensive Care units, providing concentrated nursing care supplemented by technology.

CENTENARY WING

The Centenary wing of 1945 commemorated HDH's first century in Kingston. Completion was expected by 1947, as well as other renovations and fireproofing of the existing Hospital. The new wing, 65 x 100 feet, would contain the Paediatrics and Obstetrics departments, offices and service rooms, bedrooms with private baths, and a solarium on each floor. Estimated cost was $400,000, and more than $300,000 from the campaign was on hand. On National Hospital Day, May 12, 1950, the official civic opening took place.

In December 1960, the Centenary 3 Solarium was converted to provide the laboratory with sufficient office space. On January 12, 1963 the Obstetrics Department moved to

Centenary 3, except for Centenary wing beds and the Case room on the fifth floor. The Nursery moved to the Centenary 3 Solarium. The old room was transformed into a new Recovery unit with 12 units and a respiratory section, in conjunction with renovations on the fifth floor and the operating room theatres.

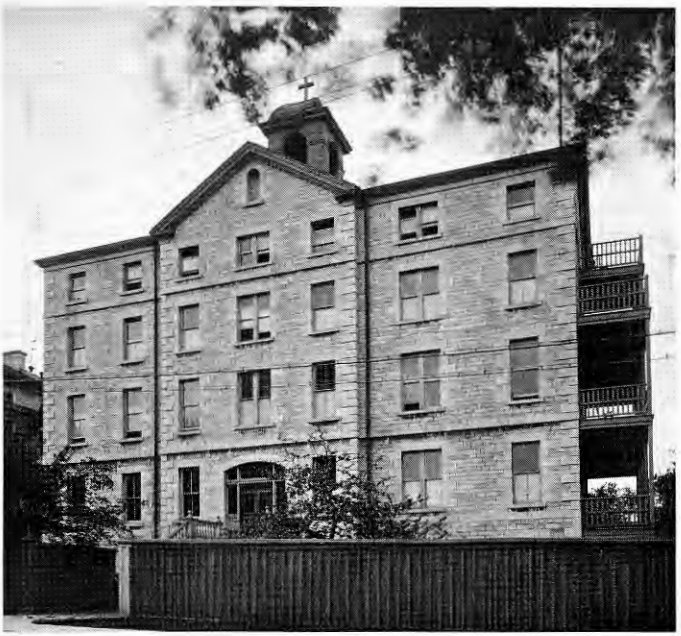
Today, Centenary houses the Pharmacy (1), laboratories (2), offices (3), endoscopy preparation and recovery facilities (4), and an 18-bed psychiatric inpatient facility (5).

JOHNSON WING

In 1958 the Board approved the Planning and Development Committee report for demolition of the monastery and erection of a new east wing of seven storeys, a dining room, cafeteria and new kitchen on the first floor, completion of an out-patient addition, and expansion of the laundry and boiler plant. Later, plans were changed several times.

On March 1, 1961, the Ontario Hospital Services Commission announced approval in principle of the planned renovations and additions; and on April 19 the Kingston City Council granted $10,000/year over 10 years for the new building fund. Preliminary work on a funding campaign began on March 5, 1962, and on May 2, campaign organizers were appointed, under Hugh Gibson QC as Chair. On June 4, a "digging-in" ceremony with the sod turned by Gibson using a gold-plated shovel launched the million-dollar campaign. Ninety percent of the employees pledged at least one week's salary, and 25 percent of the staff doctors more than $60,000. On June 21, the Frontenac County Council toured the Hospital, and later voted $40,000 towards the fund.

On December 4, tenders were issued for construction of the new wing as well as needed renovations. Included were a new six-storey wing on Johnson Street, a new Emergency Department between St. Joseph's wing and the convent, and additions to the laundry and boiler room. On February 6, 1964 final government approval was received for the building, and demolition began on the old monastery, a Johnson Street landmark since 1898, to make way for the new wing. On February 10, excavations for the new Emergency Department began, and on February 24, work began on the main entrance, with Admitting moved from beside the Chapel to the former Doctors' Room beside the switchboard.



Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Monastery (residence of Sisters), 1898 - 1959, circa 1900.

On June 12, 1964 the cornerstone of the new wing was laid by the Apostolic Delegate Archbishop Sebastiano Baggio. Records show that the canister included a new mint penny, 5 cent, 10 cent, 25 cent, 50 cent and $1 coin, and an American 50 cent piece with the head of John F. Kennedy. Stamps, the Nurses' graduation program, the program for the day, newspaper clippings, a picture of the old convent bell, a list of signatures of Sisters residing in Kingston, a rosary from the present costume, a copy of the Annual Report and one of the Hospital Bulletin, and some medals were all included.

On January 4, 1965 the new Emergency Department opened, as did the passageway connecting the Centenary wing and the second floor of the convent on January 22. On the 29th, the tunnel from the Hospital to the laundry, which had been closed because of construction, reopened. New power plant and laundry construction began on March 22. On March 24, while blasting rock near the power house, a small explosion occurred. Two cars parked on Johnson Street and some Johnson Street houses were damaged. A rock the size of a filing cabinet went

through the roof of the boiler house, just missing one of the boilers. Fortunately, no one was injured.

On November 20, the kitchen and cafeteria facilities of the new Johnson wing officially opened. Dietary had occupied the area between Brock Street and Centenary wing since 1929. Until the late 1940s, a familiar autumn scene was fruit and pickle canning bees in the courtyard between the monastery kitchen and the Hospital.

In 1966 the new Johnson Street wing, primarily dedicated as a patient care area but also containing Emergency and Dietary was completed, the fifth and largest addition to the Hospital in 118 years. It cost $4.7 million, and included 148 beds, improved outpatient, emergency, x-ray, kitchen, teaching and lecture facilities, and a new laundry and extension to the power house. The Emergency department was completed one year later. The total four-year building program amounted to $5.5 million.

As with all other hospital wings, changes came to Johnson. Johnson 4 was vacated by Obstetrics in 1973 when it moved to KGH, and renovations were announced in January 1974 for intensive care units (ICUs), at a total cost of $100,000. Both the surgical intensive care unit and the medical intensive care unit opened in 1975. (A new ICU opened in the Jeanne Mance wing in 1984.) On May 1, an open house was held for the newly opened burns unit, which contained an air-fluidized bed for badly burned patients for this area of eastern Ontario.

On July 5, 1979, Paediatrics on Johnson 6 moved to Kingston General Hospital. Johnson 7 underwent renovations in 1978 to receive Orthopaedics; and in the early 1990s the entire wing was renovated at a cost of $2.3 million to bring it up to current safety and environmental standards. Renovations, completed in January 1994, included upgrading of elevators, a new call system, provision of emergency power and improved lighting to patient rooms, new medical gas lines and fire alarm system, better ventilation, and removal of all asbestos, as well as cosmetic enhancements to the nursing stations.

Today, Johnson houses research space (0), Nutrition Services and the cafeteria (1), laboratories (2), surgical inpatients and the burn unit (3), the endoscopy suite and 18 gastrointestinal inpatient beds (4), psychiatric outpatients (5), a 37-bed medical inpatient facility (6), and a 37-bed surgical inpatient facility (7).

FAMILY MEDICINE CENTRE

The Canadian Register building at the corner of Bagot and Johnson Streets became part of the HDH complex in 1971. On August 28, 1974, the building was demolished, the site prepared, and on October 26 grant funds were announced for construction of the Family Medicine Centre to provide a facility for health care and to expand the role of family physicians in the education of medical students. The new unit opened on June 26, 1976. On June 28, 1978 the administration offices of the Department moved into the building.

Today, outpatient clinics and offices occupy the basement and two storeys of the building.

Hotel Dieu marked its 125th anniversary with an open house program on October 14th, 1970, including displays of pictures and artifacts, and tours of the facility.

JEANNE MANCE WING

Plans were announced on October 10, 1974, for a new operating room suite and other support services in an eight to 10 storey wing on Brock Street on the site then occupied by the Jeanne Mance Residence of 1948 to 1973 and the adjoining parking lot.

In 1978, tenders were called for demolition of the Jeanne Mance Residence on March 22, completed by May 29. Site preparation included relocation of major services such as sewer, water, and electrical and oxygen supply lines. On March 9, 1979 the official "digging in" in the area of the former Jeanne Mance Residence was celebrated: Minister of Health Dennis Timbrell, who used to play as a boy in and around HDH and whose father had owned a garage on the corner of Montreal and Brock Streets, used the large back hoe. On May 29, the new $18 million Jeanne Mance wing was officially announced. On May 25, 1982, a Topping Ceremony for the Brock Street addition was held to celebrate the roofing in of the seven storey structure.

This wing was the third phase of the Hospital's redevelopment project and rationalization of services in the Kingston area, and was built to house emergency and ambulatory care areas, the operating suite and critical care units, the medical imaging

department, and paediatrics — a new in-patient unit, a children's centre and an outpatient clinic. It permitted the move of the amalgamated paediatric service to HDH.

By November 1983 the Jeanne Mance wing was nearing completion, and the dedication was set for May 17, 1984, the 342nd anniversary of the date in 1642 of Jeanne Mance's arrival in Montreal. A life-size bronze statue (possibly the only one in Canada) of St. Joseph the Worker by Alexander von Svoboda, who also designed the Chapel Resurrection, was installed over the entrance to the building on November 2, 1983. The actual casting of the five foot six inch 784-pound statue was done in Florence, Italy in 1983. Between 3,000 and 4,000 people toured the wing in December.

In 1991-92 the inpatient paediatric floor was renovated, at a cost of $26,250, to create a short-stay unit for children needing observation or overnight stays. Among the new facilities were seven new operating theatres accessed by staff through a central corridor and by patients through outer corridors. An airflow system injects sterile air into the middle corridor. The air then flows through the operating rooms to the outer corridors. Operating rooms, recovery, intensive care and coronary care units were now located on the same floor.

The Physiotherapy department was also relocated, from the basement of one of the oldest sections in the Hospital to an area near the new main entrance, with floor space nearly doubled, better ventilation and more cheerful atmosphere. Space was now available for staff educational and patient information programs.

At present, Jeanne Mance houses Facilities Management (00), Radiology, Stores, central sterilization and Emergency (0), admitting areas, lobby, children's outpatient, physiotherapy, and Child Development Centre (1), operating and recovery rooms, including the intensive care units (2), Paediatrics, with 46 inpatient beds and a five-bed paediatric intensive care unit (3), and administration offices (6). Presently untenanted are 4 and 5, which will soon be used for psychiatric inpatients.

THE MURRAY BUILDING

The Hospital received approval in 1974 to complete ownership of its full site. In 1976 it purchased the Public Library at the corner of Bagot and Brock Streets through the Ontario

Health Resources Development Fund. The old building received a facelift, as grime and dirt were removed, while on April 22, 1978, the new Kingston Public Library opened on the site of the Notre Dame Convent on the corner of Johnson and Bagot Streets. On November 20, 1981, the Murray Building, named in honour of Mother Cecelia Murray, first Superior General of the English-speaking RHSJ, was dedicated and officially opened. It housed Otolaryngology, Audiology and Human Communications Unit, and eventually would be joined to the Jeanne Mance wing and the rest of the Hospital. In 1991-92 a new audiometric sound room was built in the ear, nose and throat clinic, with an expanded waiting area for patients. Funded by proceeds from the 1990 Auction, the work cost $36,363. Today, the basement and the building's two storeys are occupied by Otolaryngology and Audiology.

MARY ALICE WING

In September 1982 the former convent area was named the Mary Alice wing in memory of Mary Alice Murray, first woman Chair of the Board of Directors and niece of Mother Cecelia Murray. It was converted to conference rooms and employee health services. Two self-contained rooms were assigned to Pastoral Care workers on night call. In 1991-92 the wing received a new facility to house staff lockers, washrooms and shower.

On January 27, 1994, in one of the coldest winters on record in Kingston, a cast-iron valve in an electrical room on Mary Alice 2 froze and split at about 9 p.m. Water began pouring down the Mary Alice ramp and into the Sydenham wing, out the Sydenham entrance, and into the street. It took about an hour before the source could be located and the water shut off. By that time water had collected in elevator shafts and on office floors, affected Sydenham 1 storage areas and the linen room as well as the eye clinic on Mary Alice 1, and part of the kitchen and pharmacy on Johnson 1. Damage estimates amounted to $50,000. Fortunately, no staff were working in the affected areas, and the flood did not affect inpatient care. A number of departments and employees responded quickly to the emergency, and all areas were fully functional although somewhat damp the next day.

Mary Alice (1) houses the eye clinic, the Chapel and Occupational Health and Safety (2), offices (3 and 4), and the resident sleep areas (5).

SUPPORT FACILITIES

On June 8, 1946, $70-$80,000 was spent on a modern heating plant and laundry in the lower part of the garden on Johnson Street. The fireproof building, about 55 x 100 feet, included a tunnel from the main Hospital building to the laundry which would be part of the heating plant. The power plant, which would be one of the most modern heating plants in Ontario, was equipped with high pressure boilers.

In 1978-79 at a cost of $1 million, a steam line was constructed from the Queen's heating plant on King Street across Barrie Street, through Sir John A. MacDonald Park, crossing Bagot Street, turning right on Johnson and along Sydenham, to enter HDH under the cafeteria. On November 1, 1979, months, even years, of preparation paid off. The heating plant was shut down, and in one hour, HDH was on the main pipe line and in full operation from the Queen's University heating plant. The line belongs to HDH and is an important connection in the communication network, since conduits for wiring were laid along it, permitting HDH to share University lectures and audiovisual programs on its premises, and enrich the teaching and research functions of the new laboratories and nursing units.

STAFF FACILITIES

Healthy employees do not require as much sick time as their unfit counterparts, and are better able to provide care and support to their patients. The HDH Fitness Centre was established in 1985 on Sydenham 5. It consists of two areas, the larger used for group exercise classes, and the second designed for employees on individual exercise programs. The staff encourage a safe and sensible approach to fitness. Members are entitled to diet and nutrition counselling from a dietitian, and a physiotherapist helps set up sound exercise programs. The Centre received a Wintario grant of $3,000 from the Ministry of Tourism and Recreation to further develop and enhance the level of service to employees, and purchased an eight-station global exercise unit, a sound system, free weights and a rowing machine.

The next major expansion will take place at the site known as 10 Montreal Street, a three-storey building purchased in 1992, for two reasons. First was its strategic location, directly across from the door of HDH and adjacent to the parking garage used by HDH patients. Second was the need outlined in a current long-term plan for HDH to develop new and modern ambulatory care space properly designed for the teaching of interns, residents and other health care professionals. One of the most important items in HDH's share of Healthcare 2000 is the expansion of ambulatory facilities. HDH, like virtually every other hospital in Canada, never realized the amount of ambulatory space that would be needed for day care programs, outpatient programs, day surgery, etc. Space will also be needed for students, clinical teachers and classrooms. The site provides HDH with the opportunity to develop an ambulatory structure physically linked to the parking garage and the Hospital by overhead walkways to avoid risk to mothers and children and wheelchair patients crossing Brock Street, especially during Kingston's five or six months of poor weather. The location is also the hub of bus transportation in Kingston. It presents the real possibility of combining development with some commercial enterprises, a health care centre with potential for ophthalmologists, optometrists, audiologists, suppliers of hearing aids, and a wide variety of health-related organizations. The planned building could open in the year 2000.

Over the years, concerns and focuses inevitably changed at Hotel Dieu. At first nursing Sisters made up the entire staff, and the Hospital's role was caring for the sick and needy. But by 1970, 125 years later, that role had broadened, and its philosophy had been restated to a commitment "to serve with Christian love and excellence the Community for patient care, the university for teaching and humanity for research in medicine." Today (1994) there are 367 Registered Nurses and 79 Registered Nursing Assistants at HDH.

In 1918 HDH became affiliated with the Catholic Hospital Association in the United States and Canada, formed in 1915; and shortly thereafter the medical staff became organized, dividing the medical work of the Hospital into various departments. Initially, these departments included medicine, surgery, obstetrics, and eye, ear, nose and throat, along with a consultant in psychiatry and neurology, a bacteriologist and a pathologist.

In 1920, hospital standardization in both Canada and the United States became a reality and government regulations a fact of life. Hospitals were checked yearly and accreditation granted to those with acceptable standards. HDH was one of the first in Ontario to achieve accreditation, and recognition for excellence as well. On June 27, 1921, Dr. Thomas R. Ponton visited officially on behalf of the American College of Surgeons. As a result of his report, the Hospital was ranked among the first of the American hospitals. On August 7, Rev. Father Charles Moulinier, S.J., of the Catholic Hospital Association, also paid an official visit. Once again HDH received the highest rating. In 1931, meeting the requirements for the training of interns, HDH received approval for rotating internships. It also played an important role in Ontario medical affairs. The Ontario Hospital Association was formed in 1924, with Dr. Edward Ryan of HDH a member of the first executive.

Ever since the Queen's School of Medicine opened, there had been a limited teaching connection with HDH. Following the move to the Regiopolis College building, the increase in hospital beds allowed weekly clinics to be held. In 1902, a "4th proposed agreement" between Queen's "College" and HDH was drawn up and, according to HDH archives, accepted. The agreement opened the wards and operating room to Queen's medical faculty

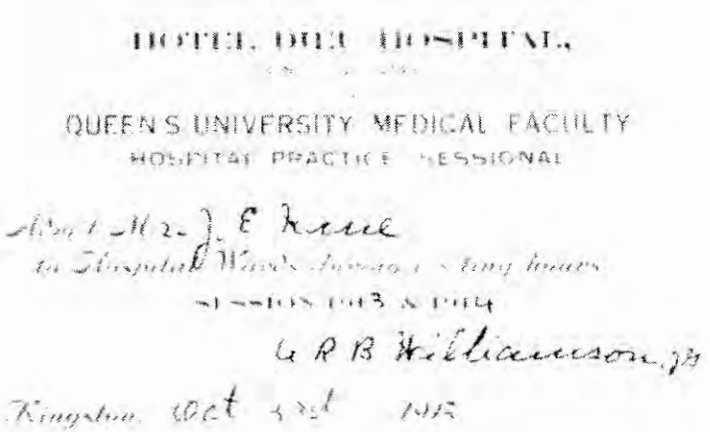
for clinical purposes. Professors of surgery, medicine, gynaecology and ophthalmology, otology, rhinology and laryngology could now give clinical instruction using their hospital patients. HDH received one-fifth of the hospital fees paid by the students per year. Instructional hours, which could be expanded or changed, were laid down. Only six students could be admitted to the ward clinic at any one time, and students could visit the Hospital only during teaching hours and accompanied by a professor. The clinical lecturer was responsible for the behaviour of the students in his charge.

During the first half of the 20th century, clinical instruction was given in groups mainly on public wards at KGH and HDH. Some courses, because of space limitations, were given in strange locations. Dr. H. Garfield "Gub" Kelly, former Vice-Principal Health Sciences at Queen's, remembered when, just prior to the Second World War, HDH physician "Fergie O'Connor Senior gave the university course in obstetrics, and he used to give that in the old autopsy room at the General in the Richardson Building." Medical students received instruction in physical diagnosis at St. Mary's of the Lake, and in psychiatric disorders at Kingston Psychiatric Hospital. However, emergency departments and ambulatory care facilities were small, without regular staff, or an organization which made clinical teaching impossible. Interns and residents were appointed by the Hospital after discussion by the Superintendent with the appropriate clinical teachers, not on a formal recommendation of the University.

On December 26, 1945, a new system of provincial government grants for hospitals in Ontario was instituted. Teaching hospitals received a high rating, and HDH benefited from a "greatly increased" grant.

Dr. William R. Ghent, Chief of Surgery from 1957 to 1974, arrived at the point of HDH's transition from community hospital, giving exemplary patient care but not considered a "university" hospital, to full-fledged teaching hospital and equal member in the future Health Sciences Complex. His was the first full-time position created, and he was the first full-time Head of Surgery. "The next was Doug Waugh, who was Head of Pathology, and third came Jack Milliken in Cardiology," said Dr. Ghent. "Those were the bases or building blocks upon which we were able to build a hospital that now provides primary, secondary, and tertiary care. The basics of the transition were all in place in the mid '50s."

In 1955 the Hospital, in an historic move, became fully affiliated with Queen's University, and was approved by the Royal College of Physicians and Surgeons of Canada for selected specialty training. Results of the affiliation were staff appointments in 1956 from Queen's University with Dr. John A. Milliken becoming Chief of Medicine and Dr. Ghent Chief of Surgery; on June 6, 1960, Dr. Milliken was appointed Associate Professor at Queen's University. The Hospital assumed an even more important role in the medical school in 1963, when Dean of Medicine Dr. E.H. (Harry) Botterell began establishing clinical teaching units there — beds set aside for use only by geographic full-time staff.


HOTEL DIEU HOSPITAL,

QUEEN'S UNIVERSITY MEDICAL FACULTY

HOSPITAL PRACTICE SESSIONAL

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Hotel Dieu Hospital/Queen's University admission card, 1913.

At the same time, HDH and Queen's Medical School became increasingly important in regional health care. Although more people were living longer, there were now more chronic ailments, rising health-care costs, and a need for more doctors and other health care professionals. Local hospitals needed to take on additional training responsibilities; and the signing of the agreement dealing with clinical teaching units on June 24, 1966 formalized the clinical training of medical students, interns and residents.

Medical schools have always functioned as regional health centres, because of their facilities and resources. But there were four key developments in the transformation of

Queen's medical school and the local hospitals including HDH into a progressive Health Sciences Complex.

First, in 1959 the inauguration of the new Hospital Insurance Plan of Ontario removed the distinction between the public and private patient. Second, the government's creation of a health resources fund revitalized health sciences centres. Third, the emphasis in clinical teaching shifted from declining numbers of inpatients to outpatients flocking to the newly created ambulatory teaching clinics and the integrated emergency department services at the two Kingston hospitals. Fourth, the Royal College of Physicians and Surgeons of Canada now required university approval of appointments to teaching hospitals of all interns and residents. Affiliation agreements between the university and health-care facilities, including HDH, expanded and became still more formalized. Health resources required multi-disciplinary planning, education and research, and a team approach to health care delivery on a regional basis was now needed.

The Province of Ontario established a program to evaluate its five health sciences centres: Hamilton, London, Toronto, Ottawa and Kingston. Using provincial guidelines, Kingston began to review the acute care services in its catchment area. In the first step toward rationalization of services between HDH and KGH, a functional long-term plan was prepared to develop the health sciences centre, recommend the distribution of major functions in patient care, education and research, and determine functional priorities, phasing and cost control.

But health care program quality could not be reviewed in isolation. KGH and HDH as active treatment hospitals agreed to function in a complementary fashion as Principal Teaching Hospitals of Queen's University. HDH's expanded role stressed primary and continuing care in children and adults, family medicine, a community-oriented psychiatric department, some medical and surgical services, and eye, nose and throat services. KGH became the resource for all other services, including such high technology services as open heart surgery, neurosurgery and renal dialysis. The excellent cooperation between the two hospitals at the executive and administrative levels helped smooth the rationalization road.

Further to ensure that the hospitals functioned in as complementary a fashion as possible, Dean of Medicine and later Vice-Principal Health Sciences Botterell instituted a geographic

full-time system of appointing medical staff. They received their salary and rank from the university, but their net professional income was limited to devote more time to teaching and research. Surplus earnings were deposited in a trust fund and used mainly to recruit skilled clinical teachers in an area of shortage or where innovative change was needed.

Another important development was the establishment of joint University department head/Hospital chief of service appointments, designed to unite the teaching hospitals in the recruitment of outstanding clinical teachers, by appointing them as both Head of a clinical department in the University and as Chief of the same clinical service in the principal teaching hospitals. There had been some resistance to this movement. At times one or the other party felt it had not been consulted appropriately, and ruffled feathers had to be smoothed. One stumbling block had been the appointment of the Heads of Queen's departments to their departments at HDH, an idea that met with some disfavour. Those appointments have great advantages, according to Monsignor J.G. Hanley, former member of the HDH Board of Directors. "It keeps a constant flow of information between the people that are working in that department in both places and with Queen's. It also ensures that the quality of service will be maintained at a proper level because they've got to maintain university standards in both hospitals."

KGH, HDH and Queen's University formed a Joint Liaison Committee, composed of the Executive Committees of the two hospitals and the senior administrative officers of the university. Meeting regularly, the members of the committee became much more understanding of one another's problems, ambitions and plans. Shortly thereafter the membership was expanded to incorporate Kingston Psychiatric Hospital and St. Mary's of the Lake Hospital; and, with the increasing concentration on in-home services and the shift from inpatient to in-and-out surgery, it became obvious that the Kingston, Frontenac, Lennox and Addington Health Unit and Home Care needed to be integrated into the planning apparatus.

The basic principles around which the Committee operates are clear and simple, says Vice-Principal Duncan Sinclair. "Every contributor to the Health Sciences Centre had to have security that it would have a significant and substantial meaningful role in contributing to the work of the whole Centre. A second basic principle was that, while we were committed to

planning together and working together, each institution would retain and strengthen its individual identity, character and values. In that way we would achieve all of the advantages of doing things together, and retain all of the advantages of being independent. We would retain and utilize institutional loyalties so that you had the differences in the character of the institutions that make up the Centre, but we could achieve the economies of scale and rationalizing that are held out to be advantages of merged institutions. We were going to maintain a voluntary association of happily independent institutions."

In 1966 Eric Brown, a member of the administrative staff since 1961, became HDH's first lay administrator, following in the path of that first lay administrator, Jeanne Mance.

An omen of things to come, in 1968 the Catholic Hospital Association warned of a more liberalized abortion law, and on August 26 the Criminal Code was amended to permit therapeutic abortions, although hospitals were not required to allow abortions to be performed. In June 1970, in response to this relaxation, the Catholic Hospitals of Canada announced a new code of ethics that did not allow abortions in Catholic hospitals, a ruling that was to have a lasting effect on the services offered by HDH.

In 1969, pressure from both federal and provincial governments to reduce duplication and costs prompted a more formalized relationship between HDH, Queen's University, and the other health care institutions. A merger of services between Queen's, KGH and HDH marked a major change in medical relations in the city. Queen's University and Affiliated Hospitals Planning Council (QUAFHOP) was formed.

At the end of August 1968 officials were notified that the Ontario government had the funds to proceed with a medical sciences complex. A cost-sharing agreement between the Federal and Provincial governments had led to the establishment of the Health Resources Fund, to modernize and increase health sciences resources for teaching, research and patient care. At first, the Provincial Government indicated that about $100 million would be allocated to Kingston to rebuild the old and outdated facilities on the Queen's campus, at KGH, HDH, and St. Mary's.

This regeneration of HDH as a teaching hospital was not without its pangs. HDH feared the destruction of its mission as a Catholic hospital, and first news of the proposed funding created concern at the Hospital, said Monsignor J.G. Hanley. But HDH

had little choice. "If we hadn't moved forward in this way, we wouldn't be here now. It might be an old folks home or something like that....but it wouldn't be a hospital, not an active hospital anyway." To maintain qualified medical staff who would otherwise go to KGH, it was necessary to join with KGH and Queen's University. "What the administration and the Board would have had to do would have been to....try to keep things going at Hotel Dieu and hold out as long as possible and provide caring service, personalized care but not highly qualified care, for a few Catholic patients; but you wouldn't have many patients left either because the Catholic patients would be over where the technology was available and the good doctors were working..."

Now needed was a mechanism to review and analyze the education and service relationships in health care among the institutions, and to define the needs and priorities in a way acceptable to all. A Planning Council was formed, initially by the four Hospitals — KGH, HDH, St. Mary's of the Lake and Kingston Psychiatric — and Queen's University. It was agreed that Queen's would construct a new building to house a health sciences library plus medical office and research space. Both HDH and KGH would upgrade and renovate buildings dating back to the early 1800s. HDH would build a new wing and KGH a new inpatient tower. Each hospital would maintain its own support services. Ultimately, hospital beds at HDH and KGH would increase from 900 to 1,020. St. Mary's of the Lake needed remodelling to improve the quality of inpatient and outpatient care for the elderly, chronically ill and those needing rehabilitation services. However, development of a modified role for Kingston Psychiatric Hospital was limited by the special relationship between the Ministry of Health and psychiatric hospitals which allowed virtually no local autonomy.

The first milestone in the construction of the Health Sciences Centre was the opening on November 3, 1971 of the ninth and tenth floors of the Walter T. Connell Wing at KGH. The Kingston Health Sciences Complex came into existence in 1972, when the formal agreement was signed. The original Planning Council was succeeded by the Health Sciences Complex Council which held its first meeting in January 1973.

Under the Ontario Health Resources Development Plan, effective in 1973, teaching hospitals received 100 percent funding of capital projects to upgrade outdated facilities. For community hospitals in southern Ontario, the Ministry of Health paid

two-thirds of the capital construction costs. This funding was to receive a major blow when, with escalating health care costs, the Ontario government at first froze all funds. It then stated that planning must be made around a cash flow of about $5 million/year for 10 years (in addition to funds already allocated for a handful of specific projects).

The Council was told it must reduce the active beds from 900 to 800 and consolidate obstetrics in one hospital. Further reductions could be expected. Therefore, the plan to increase beds to 1,020 was revised: HDH's allotment was increased to 300 and that of KGH reduced to about 500. The Health Sciences Complex Council had to define clear program objectives and approve all programs relating to health science education regardless of location. Institutions must integrate programs, avoid duplication, increase efficiency and decrease cost.

The Council permitted the several institutions involved to respond to public policy in a new and innovative way. For example, government policy stated that 50 percent of medical graduates must become family physicians providing primary and continuing care. The University therefore established an academic department of Family Medicine, the first new department in the Faculty for many years, located at HDH in keeping with the functional program for that hospital. Within the new Health Sciences Complex, HDH's role was clarified. The Hospital would remain a community-oriented hospital base of 330 beds, with special interests in Family Practice Medicine, Paediatrics and Psychiatry, but it was now a university-affiliated hospital with responsibilities for teaching and research.

The new Health Sciences Complex involved the same four hospitals. With Queen's University affiliation, it would require an organizational and administrative structure to replace the current Queen's University and Affiliated Hospitals Planning Council (QUAFHOP). Planners also recognized that St. Lawrence College of Applied Arts and Technology, mandated in 1973 to take over the training of diploma nurses, nursing assistants and medical technologists, should also participate in the future Complex and become a full member of the present Council.

As the Complex plans developed, the Boards of HDH and KGH soon saw the advantages of developing closer links. By 1986, through reciprocal agreements, symbolic of the excellent level of cooperation and planning between the two hospitals, a

Trustee from each hospital was sitting on their respective Planning Committees.

Physical adaptations were also required, such as HDH's purchase of the Canadian Register property. Finances, as always, were a concern, particularly the division of costs for the Health Sciences Complex between the two funding programs. Although the Health Resources Development Fund would provide 100 percent financing for research and teaching facilities, health care services functions would qualify only for the provincial Capital Financial Assistance program. At least one-third of the funding was left as the responsibility of local institutions and the community they serviced.

On December 16, 1971 alternative plans for future construction at HDH as part of the Queen's University Health Sciences Complex extension were presented, costing between $12 million and $13.5 million.

The Ministry of Health gave the go-ahead on the medical complex on April 21, 1972. Then came the signing, on November 15, of the "son of QUAFHOP", an agreement concerning the Health Sciences Complex between Queen's University, St. Lawrence College, KGH, HDH, Kingston Psychiatric Hospital, and St. Mary's of the Lake. This formalized the organizational concept that saw KGH and HDH become the principal teaching hospitals for the Queen's University teaching programs, while remaining philosophically and geographically separate for community service and patient care.

But the funding carpet was pulled from under the Complex's building feet. A week later, on November 24, the Ontario government froze construction grants, put a five percent ceiling on operating budget increases, and closed more than 1200 beds in active treatment hospitals in Ontario. HDH was notified of a 38-bed cutback effective April 1, 1973.

The route to rationalization of services persisted. On December 28, 1972 it was announced that obstetrics would be transferred from HDH to KGH, effective April 1, 1973, in part due to the moral problem of family planning and abortion (prohibited in Catholic hospitals), and in part to the elimination of duplication of services. Centenary 3 was closed after Christmas 1972, and after March 7, 1973 no maternity patients were admitted. The obstetrics service at HDH, offered since 1910, had come to an end. With the transfer of 56 Schools of Nursing in Ontario to 32 community colleges on January 12, 1973, teaching

at St. Joseph's and KGH's Schools of Nursing ended. In August 1973, the students and staff of St. Joseph's School transferred to St. Lawrence College, although Kingston hospitals continued to provide practical and clinical experience. Meetings continued concerning allocation of services, resulting in the eventual transfer to HDH of Paediatrics, Psychiatry, and Nose and Throat services.

Administration at HDH itself also changed. On July 16, 1978 Eric Brown became Chief Executive Officer, the Hospital representative on the Health Sciences Complex, and overseer of the building program and of the care of prisoners. T.J. Czap was appointed Administrator with responsibility for day-to-day affairs. Mr. Brown later resigned as Chief Executive Officer and Mr. Czap was appointed in May 1980. A period of unrest followed Mr. Czap's proposal to change Hospital staff-pension carriers and staff's subsequent unionizing, and on April 13, 1984 Mr. Czap resigned. Peace was eventually restored by the appointment of Sister Elizabeth MacPherson as interim CEO until Hugh Graham, former Vice-President of Victoria Hospital in London, took over as CEO on February 15, 1985.

Following a series of meetings, a new and more diversified Council was formed, the Kingston Regional Association for Health, Education and Social Services (KRAHESS) which brought eight institutions together. The enlarged membership of the Complex would shortly include the District Health Unit, appointed on September 23, 1981.

On April 21, 1980, HDH, KGH and Queen's University unanimously approved a revised distribution of beds, services and programs, and also agreed on a mechanism for regular program review.

The hospitals were unable to complete construction with the available Ontario Health Resources Development Plan (OHRDP) funds, and the lowest tender for the Jeanne Mance wing was $5 to $6 million higher than the cost estimate. HDH suggested to the Complex Council that it use its remaining OHRDP funds to construct the shell of the new wing and complete some badly-needed facilities for diagnostic radiology, outpatient clinics and operating theatres, but delay the completion of facilities for the departments of Paediatrics and Psychiatry until more funds became available.

The proposal stunned Queen's and KGH. The Council established a special committee and, at the suggestion of

Dr. H.G. Kelly, the University surplus of $3.36 million of OHRDP funds was transferred to HDH to facilitate the completion of the Jeanne Mance wing, especially the Paediatrics facility.

That decision to transfer Paediatrics back to HDH marked a turning point in HDH history. For the first time the Hospital offered a type of patient care not available at KGH. It was now a more equal partner.

In September 1981, bids for the completion of the wing's construction were submitted to all approving authorities; HDH received $22,134,000 for the building of the new six-storey wing, from the Ontario Ministry of Health's allotment of $120 million to the operation, expansion and construction of the 230 general hospitals in the province. $33 million of those funds came from provincial lotteries.

The Medical Advisory Committee, sometimes referred to as the Parliament of the medical staff, continued the important responsibilities of coordination. As well, governance of the RHSJ health services in Ontario saw its own rationalization proceed. The system includes health care facilities in St. Catharines, Windsor and Cornwall as well as Kingston, in Ontario; and outside Ontario, in Chatham, New Brunswick; Chicago; Antigo and New London, Wisconsin; and the Dominican Republic. In 1984 the RHSJ Health System was established to provide more effective governance, cooperation with government agencies in efficient resource use, and exploitation of opportunities for the growth of health care in all its facilities. A Health Care Council acts in an advisory capacity to the corporation, and to the Board of Directors and Trustees of the institutions comprising the RHSJ Health System.

The Health Sciences Complex was now working so well that, according to Dr. H.G. Kelly, "The Province figures this is the best functioning Health Sciences Complex in the province, even though it's the smallest, with collaborative planning and working together and joint fund raising. It's a model."

An ad hoc Strategic Planning Committee of the Board of Directors became heavily involved in developing plans for the future. Membership included representatives from the Sisters, the Board of Directors, HDH administration and medical staff, and Queen's University. The committee focussed primarily on coordinating HDH's overall objectives to meet the requirements of its expanded mission, yet remain within the context of the Hospital's philosophy. It released a Strategic Planning document

as the basis for discussions with KGH and Queen's University about the future development of HDH, and HDH entered into a phase of joint planning with KGH.

The year 1995 would mark the 150th anniversary of the arrival of the RHSJ in Kingston; and on September 18, 1990, chaired by the Provincial Superior Sister Audrey Mantle, the initial meeting of the Hospital's Sesquicentennial Committee was held.

Financial constraints, however, started to take their toll. Following budget cuts announced on January 21, 1991 forty employees were laid off, and beds closed. Of the 588 acute-care beds in Kingston, 379 were now at KGH and 209 at HDH. The Hospital made a concerted effort to keep staff informed and to explain the rationale behind the reductions; and through the Employee Assistance Program provided a social worker to assist staff members. Employees were invited to take part in the organizational restructuring through the Fiscal Advisory Committee and planning workshops.

Through rationalization of services, staff and bed cutbacks and constant self-examination, by 1992 the Hospital had developed a reputation as the smallest, most cost-efficient teaching hospital in Ontario. More, it provided high quality and compassionate care, thanks to the frugality, respect and empathy inherited from the RHSJ.

It was obvious, however, that the cost of health care was growing faster than the provincial economy. Initiatives to reduce the immense provincial and federal deficits could be expected to affect hospital operation, and in the future HDH, like other hospitals, would have to meet increasing needs with reduced resources. Concerned about future constraints, the RHSJ Health System asked the Hospital to develop a strategic plan. The discussions, held over four months in early 1993, involved medical staff, management and front-line staff, department heads, the Board of Directors, the District Health Council and other health agencies, and the public.

Among the issues were alternatives to inpatient care. Since acute-care hospitals are the single most expensive component of the health-care budget, alternative ambulatory-care programs and community-based care must be provided. Patients waiting for test results may occupy nearby hostel accommodation instead of expensive hospital beds. Pre-admission programs should allow patients to have all tests completed before entering

hospital for surgery, and patients should be admitted to appropriate facilities. Long-term care beds, for example, are less expensive than acute-care beds. The tests ordered, the appropriate treatments prescribed, the optimal length of hospital stay, must all be considered.

Finally, the public must learn what to expect of hospital service. Growing waiting lists could have a negative impact on health. Patients may be discharged earlier, and family and community agencies may need to become more involved as patients recover at home. Service delivery changes from bedside to outpatient facilities will mean modification of educational programs and student facilities in the Hospital. Staff education programs must also change. Financial constraints will affect Hospital resources, especially as demands from the growing and aging population increase. The costs of new treatment options will probably exceed any cost savings from new technology. A central booking system, a medical records system compatible with that at KGH, and ways to notify community physicians about their hospitalized patients are also required.

Ethical issues also emerged as a concern. The patient must be allowed to make the best choice about his or her care so that the services offered are not a burden. Staff and patients alike need education about living wills, treatment options and patient advocacy.

Unlike most hospitals today, HDH needs more space. The consolidation of services and expansion of outpatient clinics contain major implications for the development of some departments. As well, planning is now in progress for a new secure unit for the Correctional Services of Canada.

Recruiting of medical staff in some areas has become a problem, in part due to insufficient patient volume needing specialized medical care in the HDH catchment area, uncertainty of funding, and a shortage of some specialists. The proposed Regional Planning Advisory Committee for manpower in all southeastern Ontario hospitals is supported by HDH, which is considering hiring clinical assistants to help compensate for the reduction in medical residents.

On August 10, 1993 Hospital staff were forced to accept the provincial government's "social contract." Introduced as a measure to cut $2 billion from salaries in the public sector, the legislation included a wage freeze for all union and non-union employees for three years, and a certain number of unpaid days

of leave yearly. Staff held a candlelight vigil on November 30, 1993, mourning lost jobs and workplace changes. HDH's budget had to be cut by $2,023,000, and Hospital-wide discussions were held. In September 1993 a special non-salary expense reduction program was implemented. Although a significant number of cost-effective practices were already in place at HDH, a consulting company's report in early 1994 identified the potential for almost half a million dollars in further savings.

The system used for generations to reimburse physicians is also changing. A draft agreement was reached in early January 1994 between the province and the university, KGH, HDH, St. Mary's of the Lake, and the clinical physicians concerning a new funding scheme. The alternative funding mechanism replaces the fee-for-service earnings that have subsidized research and teaching. Funding cuts at the university and the hospitals have only compounded the problem. The plan's mechanism allows for a new method of payment. The ideal balance would provide sufficient funding for faculty in clinical departments to spend 50 percent of their time and energy in clinical service and the remainder in education and research. Under the proposed contract, funds will be available to develop a compensation system to pay clinical teachers for their clinical services and also reward teaching, research and administrative services.

The first year of the social contract legislation was successfully negotiated at HDH, in part with the help of closures over the 1993 Christmas holiday period and during the March 1994 school break. Unfortunately for the 1994/95 period, cost pressures have made it necessary for the Hospital to ask once again that eligible employees take the maximum number of social contract days during slow periods in service areas, and it has removed 16 beds from service permanently. Centenary 3 was closed and the remaining beds redistributed. Medical staff have expressed concern about the pressures on teaching responsibilities and the impact on patient care.

Employee groups too want, and will have, more involvement in decision-making and in the preparation of the Operating Plan, particularly where fiscal issues and cost-cutting are concerned. However, constraints have resulted in a new attitude in the Hospital, a feeling of caution. Change is always upsetting, and new directions may well cause future uncertainties for the staff.

Patient Care

In spite of the best intentions, that first Hotel Dieu on Brock Street faced shortcomings in patient care. 1845 was five years after the union of Upper and Lower Canada into one government. Confederation was 22 years in the future, and the American Civil War was to start 16 years later.

Delivery of patient care was simple, non-technical and far less costly than today. The Sisters administered the entire operation from housekeeping and dietary to laboratory and pharmacy, depending on the medical practitioner for clinical expertise. Expenses were met by donations and services from benefactors. To rescue themselves from anxious creditors demanding immediate payment, the Sisters baked bread and sold it on city streets.

In comparison, health care institutions today require highly educated professionals and excessively priced technological equipment. Even with medical insurance payments, escalating costs make government funding and grants vital for continued operation.

In 1845, medical science was just emerging from the Dark Ages. In Vienna, Ignaz Semmelweis began his research at the obstetrical hospital into the causes of "childbed fever". The first ether anaesthetic was administered in Boston in 1846. Plaster-of-Paris was used for the first time by a Flemish army surgeon in 1852, and x-rays were 50 years away. The blood pressure apparatus, the sphygmomanometer, came into use only in 1895.

Because of filthy living conditions and contamination of the water supply, cholera was epidemic. It had raged in Europe in the early part of the 19th century. The first major cholera epidemic in Upper Canada struck Kingston in 1832 and brought about the immediate construction of a hospital on the site where KGH now stands. It was preceded by outbreaks of malaria and smallpox and in 1829 by an epidemic of measles that killed many children. Cholera struck again in 1837, 1847, 1849 and 1854, killing its victims rapidly. Once considered the wages of sin and the product of intemperance, in the 1850s cholera finally was recognized as the result of crowded living conditions, poor sanitation and polluted water. Even today, in spite of modern sanitation methods, the physician must be aware of the possibility of cholera. The first case detected in Kingston in several

decades was diagnosed on March 27, 1974 in a young South African visiting Kingston friends. The 38-year-old patient was discharged on April 4 after spending one week in HDH.

By 1882, even with the best medical attention, a child had a 50 percent chance of dying before the age of five, and life expectancy was 36, about half that of today. Because of badly designed sewage systems, many houses were sitting on top of cesspools. Some outbreaks of typhoid were traced to indoor plumbing carrying contaminated water into the home. By 1928, when more than 75 percent of water used for domestic purposes was chlorinated, the typhoid death rate plummeted.

Tuberculosis was the number one killer in the province for most of the 19th century. The bacillus responsible for tuberculosis was identified in 1882, but it was to take three generations before "consumption" became a rare disease in North America. Unfortunately, today a new form is now making an appearance, a multi-drug-resistant strain, associated with those with compromised immune systems due to HIV infection.

When the newly-formed Connaught Laboratories began producing vaccines and antitoxins for distribution to the general public in 1916, deaths from diphtheria dropped from 31 per 100,000 in 1908 to 12 per 100,000 in 1918. In 1923, diabetics began to receive free insulin, discovered two years earlier by Dr. Frederick Banting and his assistant Charles Best, working at the University of Toronto. The discovery, considered the most important breakthrough in 20th-century medicine, won Banting the Nobel Prize.

Polio spread rapidly in hot summers when people crowded public pools and beaches. During an epidemic, beaches were deserted. In 1955 the province received a supply of the vaccine developed by Dr. Jonas Salk and distributed it to school children. In 1958 only 20 polio cases were reported; 15 had not been vaccinated. Even in the 1950s, until Salk vaccine became available, polio was life-threatening.

In spite of the best efforts of Hospital staff, before the days of modern drugs and surgical techniques much of the care was palliative. Today, each patient is cared for by a health-care team which can consist of a physician, home-care worker, surgeon, nurse, social worker, physiotherapist, nutritionist, or pastoral-care worker. Each member liaises with the group as a whole, and at the same time educates the other professionals. Patients also come into contact with staff from Housekeeping,

Accounting or Admitting Departments, and with volunteers who provide special comforts that the Hospital simply does not have the resources to offer. Every person at HDH, in the broad sense, is part of the health care community.

Over the years, occasional disasters, explosions, earthquakes and fires have disturbed the complex pattern of birth, life and death struggles.

On February 5, 1933 about 5:15 p.m., fire was discovered on the men's floor, St. Benedict's ward, in the men's clothes cupboard. Fortunately the fire was extinguished without injury. On November 1, 1935, at 1:10 a.m., the Sisters were awakened by the rumbling of an earthquake. "A number of patients were quite alarmed. Sisters also," the Annals report. On October 12, 1958, at 11:40 p.m., the Hospital was rocked by an explosion in the elevator shaft at the main entrance, caused by a leaking gas pipe. A small blaze resulted but was quickly extinguished. Although several windows were shattered, no one was injured.

At noon on November 7, 1967, fire struck again, this time causing a fatality. Although the fire actually started in the x-ray storage room in the basement of the Brock wing and was confined by fire-resistant materials, unfortunately a sealed-up dumbwaiter that came directly from the basement opened in one room on the fifth floor, occupied by three female patients of Dr. John Hazlett. Heavy black smoke poured in, and 18 to 20 patients had to be evacuated from the immediate area, a total of 125 in all. At one point Dr. James Henderson, equipped with an oxygen mask, and Drs. Hazlett and Donald G. Workman and nurse Ethel Scrutton with wet towels over their heads crawled on the floor trying to rescue their patients. It was unfortunately impossible to save one patient, 62-year-old Mrs. Stella Breen of Enterprise, mother of Frances Breen, St. Joseph's School of Nursing '64, who was being treated in traction and sandbags for a fractured thigh bone, and was allergic to smoke. The fire department was unable to bring a crane to reach her into the central core of the building where the only usable window was. Even though eventually ladders were extended up to the window, it was impossible to save her. She died of smoke inhalation. Dr. Gian Paloschi was removing shotgun pellets from 43-year-old Arthur Funnell in the operating room at the time of the fire. The doctor and anaesthetized patient were transported hurriedly to KGH. It was discovered that Dr. Paloschi did not have operating privileges at that hospital, and it was only after considerable and

somewhat acrimonious discussion that he was permitted to complete the operation.

On February 14, 1959, at 1:45 am the Sisters were summoned to help with a dance-hall fire disaster. Seventeen debridements took place in the operating room. Sixteen patients were admitted, and one with burns over 70 percent of his body died three days later.

On December 20, 1974, 12 miles west of Kingston in Ernestown, the 8 p.m. westbound Ottawa train collided with an eastbound freight. Three people were killed and twenty-two of the injured sent to HDH and 18 to KGH. Letters of thanks were later received from many of the injured regarding the "personal touch" felt at the Dieu. Early the following year the Hospital coped with still another accident. On February 20 in a carpet factory in Belleville, four men received severe electrical burns and were brought to the burns unit. Two died, one on admission and one a week later.

Although it is almost impossible to give the appropriate credits to all areas and units within this extremely complex health care facility, it is well worth looking at the progress in specific departments within HDH.

THE CHAPLAIN AND PASTORAL CARE

Over the years, the responsibility of the Chaplain at HDH has been to develop the virtues that characterize a Catholic hospital and thus justify its maintenance — faith, vision of the true meaning of suffering and death, supernatural motivation. Because of this motivation, the Hospital must aim for excellence: to be the best organized, equipped and staffed and the most advanced technically. Its personnel must be a united team, working hand in hand for the spiritual as well as the physical betterment of the patient.

The Hospital's first Chaplain was Father Angus Macdonell. In addition to his duties at the new Hospital, he was in charge of Regiopolis College, and was the first Roman Catholic Chaplain at Kingston Penitentiary and the Vicar-General of the Kingston Diocese.

Father Daniel Casey came to the chaplaincy from the Peterborough Diocese. He wrote "Souvenir Leaves" at the time of

the Hospital's 75th anniversary celebration in 1920, and part of one of his poems is quoted in the front of this book.

Once the Hospital grew to the point where it could afford its own live-in priest, part of the Chaplain's role included teaching ethics at the School of Nursing; and there are many kind and humourous stories about the Chaplain's relation to the nursing students.

Born in Kingston, Father James "Big Jim" Sullivan came to HDH in 1938. He taught Christian doctrine and ethics to the student nurses, wrote the Jeanne Mance Pledge recited by all graduates after 1942, and was foremost in promoting the creation of the historic frieze now at the entrance of the Jeanne Mance wing. It depicts Jérôme le Royer blessing the first Sisters leaving La Rochelle in 1659 to come to Canada.

Father Sullivan was "a wonderful man, big in every way including heart," says Father Kenneth Stitt, the present Chaplain. "As a young man he taught ethics at the School of Nursing. Every morning the nuns would parade the students out, inspect them, and then march them into the Chapel for Mass. Big Jim would stand with the inspecting nun. She would stop a student and say, 'You were late.' He would say, 'Well, I think you made a mistake, Sister. I'm sure I saw her at eight o'clock.' Of course he didn't see her at all. The girls never forgot that. They thought he was wonderful."

The arrival of Father Michael Farrell in 1971 was followed shortly by the reorganization of the department of Pastoral Care, giving the concept of the chaplaincy a new and more complex meaning. Archbishop Wilhelm assigned Father Brian McNally as Chaplain in 1974. Shortly after his arrival, he attended a Canadian Association for Pastoral Education (CAPE) program in Toronto, the first Chaplain to do so. During his study at Toronto General Hospital, Father Jan Appelman acted in his stead at HDH. Now a parish priest on Wolfe Island, he has a beautiful singing voice, and led the congregation in singing at almost every Mass. Father McNally, during his chaplaincy from 1974 to 1988, brought the pastoral services to a high level of competency.

A "new" kind of clergy has evolved. Since the 1930s, clinical training for clergy has been conducted on an interdenominational basis. Much of the CAPE training is supervised in-service experience in a number of hospitals. The student Chaplain must study the religious as well as the medical requirements of the patient, often on the ward with lectures being given by resident

medical staff. Together with courses in sociology and psychology, these supervised internships enable the Chaplain to learn treatment modalities within his area of responsibility. Today, the Chaplain is able to understand something of the nature of the patient's illness and the reason for the specified medical treatment.

The Chaplain's duties are broad and onerous. He must minister to patients, patients' families, hospital personnel and students, cooperate with physicians, nurses and resident staff, and assist in the public relations activities of the Hospital.

Over the years, an expansion of pastoral care occurred as the number of Sisters, who provided most of the pastoral care in the early days of the Hospital, shrank. The Department of Pastoral Care, now directed by Father Stitt, provides spiritual guidance and a humanizing influence for patients, in accordance with the statement made by Superior-General Cecile Renault in the mid-1970s: "We must bring tenderness to technology." One major role is counselling and spiritual support of patients, staff, families, and of course Sisters. Indeed, one member of the department, a married woman with three grown boys, has developed such a rapport that everyone calls her Sister. Many still think that, because the counsellor is from Pastoral Care, every woman is a nun and every man is a priest.

The department continues the teaching and evaluation of medical ethics. Sister Joan Kalchbrenner, RHSJ, currently is the Hospital ethicist (with backup assistance), and a conference cannot occur without an ethicist in attendance. The service of a formalized ethics team which evolved from a previous medical morals committee was instituted in 1989. The team is called in when there is a perceived dilemma whether or not to treat, and applies the criterion — is the treatment a benefit or a burden to the patient. All the ethics cases reflecting the RHSJ ethos are written up and used as teaching tools for medical and related professional students. "The team helps people arrive at the right decision, and of course the more it's used the more it's called for," says Father Stitt.

HDH, KGH, St. Mary's of the Lake, and Kingston Psychiatric Hospital are now developing a living-will form or advance medical directive. The Board Committee has agreed on the form, and it needs only Board approval from each institution. It is hoped that Medical Records Departments will attach a copy to a patient's chart for future reference. It is possible that

the hospital plastic health cards could carry a notification that a living will exists. New provincial legislation is being developed regarding physical and mental care for the incompetent.

The Pastoral Care department offers a 24-week recovery program, "The Spiritual Journey", so that staff members having difficulty with alcoholism, with drugs, or from abusive backgrounds can receive help. The Chaplain and the Pastoral Care workers train volunteers to do pastoral care in the Kingston diocese, the only one with such a program. Once they receive 200 hours of training, the Bishop then mandates the volunteers to work in his name within the whole diocese, doing home visiting, nursing, preaching, providing communion.

Laity bringing communion were unheard of 30 years ago, says Father Stitt. "All through the history of this Hospital, each morning the chaplain would bring communion around in a little chalice that was covered with a cloth. They would close all the doors, and he'd come down the hall with one Sister holding a candle and another with a bell. You'd hear the bell coming, and you'd know he was coming with communion. He would go in, never speak to you, just give you communion, and leave."

One HDH story is of Miss Mary Bradley, a long-time employee, who would scrub the elevator right outside the Chapel because the priest was coming on with the Blessed Sacrament, "and the elevator had to be immaculate to bring the Lord up."

In a major effort to make sure that all new members of staff, medical and otherwise, learn the history, the mission and the values of the Hospital, all new staff attend a program called "Sharing the Process," encompassing the values, philosophy and history of the Sisters. Its aim is to have every employee regardless of position know the whole vision of the Hospital.

There is one constant regret throughout the Hospital, according to Father Stitt, that the Sisters are not still living right within the Hospital. People miss having the Sister in her habit on the nursing unit, a visible sign of the Hospital's vision. Father Stitt replies, "The Sisters <u>are</u> still here."

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

St. Joseph's Ward, Hotel Dieu Hospital, 1900.

Mass is offered daily, and a Protestant worship service every Sunday. A bedside communion service is provided on request for Protestant patients. In the event of the death of a child, a special memorial service is available on request. Every six months an ecumenical service is held for the families of those who have died in the Hospital during the period. Everyone participates — the families, the medical staff, the nursing staff. Beginning in 1994, every Wednesday at noon a group of doctors have met in the Chapel for prayer time. There are of course a number of Christmas and Advent services. At Easter 1994 an old monastic service with music and light and darkness, the Tenebrae service, was resurrected after a 25-year hiatus; and the Chapel was filled.

ANAESTHESIA

At one time, the skill of a surgeon was measured in the speed with which he could perform an operation, since the only anaesthetic available was alcohol. In 1832, chloroform was used

in surgery for the first time by the Scot James Young Simpson, and ether in Boston in 1846 by James Warren. There are no records to show when anaesthetics were first used in HDH. However, according to a note by Dr. Fergus O'Connor Sr., the rule of thumb was to apply ether or chloroform until "you could stick your finger in the patient's eye and he wouldn't blink. Then he was out enough to operate."

In the 1930s, Dr. Alex Milligan was the first full-time anaesthetist in Kingston. He introduced direct blood transfusions, and gave the first spinal anaesthetics. He was succeeded by Dr. Allan Noble, who organized the department to post-war standards. Dr. Valentinas Nekus took over the department after Dr. Noble left in 1955, ably assisted by Dr. Jim Henderson. The department now became involved in far more than just rendering a patient unconscious for the surgeon. In the late 1950s it received a cardioscope, a hypothermia unit and an artificial kidney for safer surgery on vital organs. The same year the Ladies Auxiliary donated two positive pressure breathing apparatus units, and a respirometer to be used under the direction of the Department of Anaesthesia in conjunction with the Medical and Surgical departments.

In 1961, increased facilities for pulmonary studies and laboratory procedures were provided. A unit was established for oxygen therapy under the department's direction and the supervision of a qualified inhalation therapist. By 1963, a respiratory insufficiency team was formed to utilize the respiratory unit in the recovery room. Dr. Fred Wright, the first joint Chief of Anaesthesia, was followed Dr. Ray Matthews and presently by Dr. Peter Duncan. Today, the department participates in the teaching of third and fourth year medical students, as well as postgraduate students specializing in Anaesthesia.

BURN UNIT

Burn victims suffer from one of the most painful and potentially disfiguring of all traumata, and require very special care and treatment. They need privacy, and psychological and emotional support. The Burn Unit at HDH, which includes a plastic surgery unit, opened in 1974 under Dr. Kenneth Wylie in renovated space on Johnson 4 and is the only burn unit in the area. It accepts patients from Perth south, from Campbellford and Trenton in the west, and east to the Quebec border. In

October 1984 the unit was named the Shrine Burn Unit of Hotel Dieu Hospital. In 1992 the unit transferred to renovated space on Johnson 3, and expanded to include two adult rooms with a connecting treatment-tank room. The unit is located next to a 26-bed surgical ward with critical-care services for patients requiring monitoring and ventilating. Once such patients are stabilized, they transfer to the burn unit or surgical ward.

Burn patients are at high risk of infection. They are also always cold. One of the functions of the skin is to maintain body heat, and when skin is lost that function is also lost. Rooms therefore are kept up to 90 degrees to prevent constant shivering and extreme discomfort. Until fairly recently, burn patients were placed under immense amounts of bandages which were removed every three or four days under anaesthetic in the operating room. Head nurse Margaret Sanborn remembers this technique when the Burn Unit first opened in 1974. "You can appreciate the stench that would occur from these bandages draining. You could walk off a floor in the Hospital and walk onto another floor and know immediately it was a plastic surgery unit because you could smell the burn smell."

Current treatment for burns includes washing the patients in a large tub twice a day, removing the old treatment cream, cutting off dead tissue, checking the burned areas for infection, and then reapplying the cream. If the patient is suffering from a very bad infection this can be done oftener. Severely burned patients spend much longer in hospital than do most other patients, up to two to three months, which includes plastic surgery. Because of the difficulty of treating children on an adult floor, burned children are treated in Paediatrics.

Fortunately the number of patients is dropping, from an average of about 40 patients per year when the unit first opened to about 20. This drop is in part due to education, especially in industrial facilities, and in part because the days of kerosene burners and wood stoves are now almost over. Children's clothing is now much more fire resistant.

Survival rate from severe burns has also improved. At one time, someone with burns over 50 percent of his or her body would not have survived. Now, at HDH some survive with burns of over 70 percent. Plastic surgery techniques have also improved. Scarring from burns is less disfiguring. Pressure garments help smooth down scar tissue, and although the graft is visible, it is a smooth graft. The Unit can treat most burns, but

patients with extremely severe burns are transferred to larger specially-equipped burns units at other hospitals with intensive care monitoring facilities and dedicated operating rooms.

CARDIOLOGY

In 1962, the first coronary care unit dedicated to treating heart attacks was established in Kansas City. Shortly thereafter, HDH physicians began monitoring a couple of beds on Sydenham 2. On December 18, 1965, the J.P. Bickell Foundation provided a grant of $17,800 to set up a coronary care unit with monitoring equipment for six patients. In this unit, specially trained nurses provide intensive medical care and can monitor five or six beds. Telemetry monitors can be used on mobile patients. All personnel receive continuous training to improve the quality of care. Now, deaths from cardiac irregularities are extremely rare because these are recognized and treated promptly.

Cardiograms were being done at the Hospital even before the Second World War, and the first ECG unit at HDH, costing $1,350, was given in 1934 by Dr. William Gibson (father of Dr. Ed Gibson) who had been at the Hospital since the early 1900s. Today, about 20,000 per year are done, and information is computer-stored rather than on strips of paper.

HDH was also one of the first in Canada to use computerized cardiography. In 1966 Dr. John Milliken began developing a computerized ECG interpretation system that would allow cardiograms to be transmitted by telephone from outside Kingston, possibly even by satellite from northern communities. Today, cardiograms come from the Hudson Bay area, Red Lake, Atikokan, Windsor and Cornwall, even from British Columbia. Hospital cardiologists read about 1,000 per month originating outside the Hospital. HDH now has the most up-to-date computerized analysis system available, installed in the late 1980s and further upgraded in the early 1990s. It also has a mobile electrocardiogram service. Patients at home or in nursing homes are connected to a portable ECG which in turn is hooked to a telephone line. The readings are transmitted to another unit located in the Hospital.

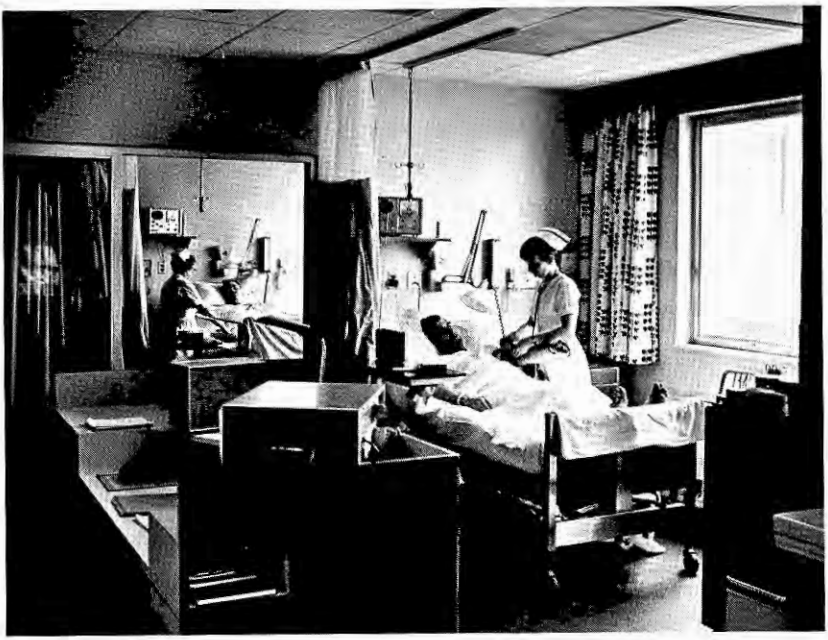


Photo by George Lilley

Medical Intensive Care Unit, 1965.

In 1991, all cardiology services were consolidated on Brock 2. Doctors' offices and diagnostic test rooms are now on the same level as the Coronary ICU, and all cardiologists and their outpatient clinics are in one area.

The Cardiology department, with its emphasis on non-invasive cardiology, sees patients needing electrocardiograms, treadmill tests, holter monitor tests and echocardiograms (ultrasound applied to the heart.) The most common inpatient diagnosis is heart attack, acute myocardial infarction, which requires urgent, competent treatment.

One new technique is esophageal echocardiography, the attachment of an ultrasound probe to an esophagoscope, which is inserted into the esophagus to examine the heart without interference from the lungs; and the echocardiography department has grown from one to three laboratories.

The Cardiology department provides education and training at both undergraduate and postgraduate levels under the supervision of an attending physician. If research grant funds permit, an echocardiography fellowship, which includes research activity, may be offered. The teaching program is closely

integrated with that at Kingston General Hospital, where the emphasis is on invasive cardiology. The two services are very closely integrated at the administration, service, teaching and research levels while avoiding duplication of programs.

Dr. Milliken sees future change in cardiac surgery. "I'd be leery of saying that cardiac surgery is going to be of the type we are now doing." One new technique using laser catheters, still very experimental, may make bypass grafts a thing of the past, he says. "They are trying to develop the type of laser that would only be sensitive to the lipid deposits in the artery. Most of the difficulty so far is that when the artery bends, the catheter may well blow a hole in it. I think when they get the technique down they should be able to do it like a balloon angioplasty, for example, and just go in and clear it out."

Although administrators anticipate some increase in demand for inpatient and diagnostic services, no major development is being planned for the near future.

EMERGENCY

When that first tiny Hospital opened its doors, the sick would stumble through the front door into the care of the waiting Sisters. Today reception of acute problems is done by the Emergency Department. Although its role has remained much the same over the years, its location has changed and its facilities have expanded. At one point, two emergency rooms staffed by about five full-time and five part-time staff were located off Brock Street, with a clinic area in the Brock wing. In the mid-1960s the service moved to a larger area, close to the new ambulance dispatch facility which replaced the ambulance service operated by funeral homes. "Some of the nurses would actually go over and monitor the radio, waiting while the ambulance was out," said emergency nursing coordinator Maureen Little. "It was a good working relationship because the ambulance drivers used to also work in the Emergency Department. If they weren't busy they would come over and help us." Emergency moved again to the new Jeanne Mance wing in 1984, and has expanded to 15 full-time and 15 part-time staff. Numbers of patients being treated have also grown immensely, from about 60 to 160 within a 24-hour period. The department now sees 50,000 people yearly.

Today, the official ambulance dispatch still operates from HDH, but the ambulances themselves are based in three

different locations. Depending on the type of illness or injury, patients are taken either to KGH or to HDH. "People with head injuries and trauma go to KGH, as do obstetrics and gynaecology. Paediatrics comes to HDH, with the exception of urology or neurosurgery trauma, as do cardiac, gastrointestinal patients, burns, plastic surgery, a lot of psychiatry, general surgery and general medicine. And there's always patient's preference," says nurse Little.

Today, physicians trained specifically in emergency medicine staff the Emergency department. But emergency medicine as a discipline was not conceived of until the late 1960s in North America, when the American College of Emergency Physicians was formed to develop a separate body for emergency medicine, as such traditional disciplines as orthopaedic surgery and cardiology had done. They also established specialty training for physicians who had completed medical school and were planning careers in emergency medicine.

In 1975 the emergency departments at both hospitals amalgamated their physicians, and in 1977 a training program was developed for specialists in emergency medicine. Dr. L. Eugene Dagnone of HDH helped establish the program which trains a total of three residents every two years, using the combined facilities of the two hospitals as well as the knowledge and expertise of allied departments. During the last six years the department has also, together with the department of Family Medicine, become responsible for training family physicians who wish to provide time and service to community emergency departments while maintaining their own practices. The training for specialists in emergency medicine requires five years after MD qualification, and for family physicians one year after the two-year family medicine training.

The department has also received strong support from Hospital administration, with teaching offices and conference rooms, as well as the regular clinical facilities, having been provided.

FAMILY MEDICINE

HDH has had a long association with family medicine through the family physicians in the community with Hospital privileges. The Family Medicine department itself started in a small way about 1968 as the Family Care Unit located at KGH,

but later expanded and changed locations. On September 8, 1974 Dr. Ernest Reginald Haynes was appointed Professor and Head of the new Department of Family Medicine at Queen's University and transferred to HDH.

The new Family Medicine Centre, opened in September 1975, was set up to train residents in family medicine, and to serve the people of Kingston and the surrounding area as one of HDH's outpatient clinics, providing continuing, comprehensive, primary health care for patients and their families. All physicians at the Centre are family physicians with their own patients and practices, and operate clinics at the Centre for teaching purposes.

The department grew over the years, at first slowly but in the last few years much more rapidly because of the change in medical education and licensing in the province. Until 1994, doctors could graduate from medical school, intern for a year and then begin practice as general practitioners. Now, the College of Family Physicians of Canada requires that a doctor either obtain College certification as a General Practitioner or do at least two years of family medicine training.

At first about 12 residents a year were being trained in the two-year program, by 1977 there were 18, and in 1991 numbers had grown to 27. Recently, 576 applications were processed and 454 interviews held just to fill 25 first-year residency positions. By 1994 there were 70 postgraduate trainees. As well, the Centre may be unique in the country in having a third year allotment of residency positions. The staff has grown to meet the need: in 1994 20 geographic full-time faculty and eight to 10 part-time; other faculty members in nutrition, social work and psychiatry are associated with the Centre. Over 100 community physicians who will provide one-month experience for medical students and residents serve as adjunct members of the department.

Today the department teaches the family medicine component in the new undergraduate program at Queen's, and its system of community teaching practice has become a model in the province. It continues to teach clinical skills, and organizes clerkships in family medicine for the fourth-year medical students.

Trainees spend 40 percent of their time outside Kingston, and 60 percent outside the tertiary care setting. All obstetrics training is done in Oshawa, Belleville and Peterborough.

Residents spend four months in a community-based practice in places like Napanee, Picton, Sharbot Lake, Timmins and Moose Factory; they also spend four months at the Family Medicine Centre itself. The program is fully accredited (whereas currently about one-third of the programs in Canada in 1994 are not accredited). Of the graduates, 75 percent go to cities of under 100,000 where family physicians are most needed.

Four full-time members of the faculty are based at the residential centre for the developmentally delayed in Smiths Falls, where some who were admitted with Down's syndrome have now lived long enough that they have Alzheimer disease as well. The department has also established postgraduate training in women's health, one of the first two in Canada, available to residents in their third post-graduate year.

It is just beginning a third year of training in aboriginal health issues, triggered in part by the Queen's University Moose Factory Program. Now almost 30 years old, the Moose Factory program described under "Native Patient Services" is the oldest linking a university and an aboriginal community. When the first visits were made in 1965, Dr. Don Delahaye travelled to Kashechewan, a small community at the end of an eight-mile trip by motorboat through a fast-moving river full of rapids. The people of the community had not seen a doctor for two months, and would not see another until after freeze-up. "At the end, the old Chief came specially to thank me with tears in his eyes. I had a few tears in my eyes, too, mainly due to shame that he should have to thank me for a minute fraction of the medical care that most other Canadians would consider their birthright."

The Moose Factory connection has allowed the Family Medicine department to train young doctors and nurses in cross-cultural medicine, delivering medical care in a remote setting where technological backup is non-existent. It also permits them to learn about broad determinants of health: poverty, clean water, housing and cultural factors. It has provided the residents in the area with access to first-class medical care.

The future of the Department is a secure and bright one, according to Dr. Ruth Wilson, who has served as department head since 1991. "Kingston, because of its size, cannot as a medical school hope to train super-specialists in every field. We just don't have the patient volume to draw on. So we have to get very good at some things. One of the things that Hotel Dieu has always been good at is providing care in the community, care in

a very deep sense. So what Queen's Medical School can do well is to train caring, sophisticated general practitioners. Our strength over the years should be to train humane well-rounded physicians with a variety of talents who can meet the needs of the province, the country and overseas."

GASTROENTEROLOGY

In 1845, the term "gastroenterology" was unknown, although certainly diseases of the digestive system existed. Lack of diagnostic equipment meant that progress in treatment was slow, especially since major diseases could develop without any signs visible during physical examinations. But techniques of patient care improved as research expanded knowledge.

The first gastroenterologist on staff at HDH was Dr. Ivan Beck, who came in July 1966 to set up a gastroenterology unit, combining a unit of 18 beds, a special laboratory for investigating gastroenterologic function, an endoscopy room, and physicians' offices at the same location on Brock 2. A research laboratory closely adjacent on Johnson 2 was also established. Since 1966 this has been one of the leading centres for the investigation and management of gastrointestinal disorders.

This was one of the first coordinated gastroenterology units in Canada. In the laboratory a wide range of tests could be carried out, and the endoscopy room had the most recently available fibre-optic endoscopes. The principle of a combined unit was established in 1966 and because of its success the new unit on the fourth floors of Johnson, Centenary and Brock, established in 1988, was built on the same principles.

There has been tremendous growth in the department. In 1970 there were five gastroenterologists in Kingston: Drs. Beck and Larry Da Costa at HDH and Drs. Leslie Valberg, Jerome B. Simon and Aubrey Groll at KGH. In 1971 the gastroenterology training programs at both HDH and KGH were accredited separately. As rationalization proceeded, these two were transformed into one Queen's, Royal College-approved program with Dr. Beck as the program director. The division has since its beginning been one of the most important centres in Canada for the training of Canadian academic gastroenterologists as part of the medical school postgraduate program.

The Gastrointestinal Diseases Research Unit was established at HDH in 1982, with Dr. Beck as the director and a staff

consisting of both medical and surgical gastroenterologists and basic scientists. This was expanded to include extensive laboratory space on Johnson 0 for the Gastrointestinal Diseases Research Unit, described in greater detail in the research section of this book. Currently, the nursing and endoscopic units are on Johnson 4, with the outpatient waiting area in a small area on Centenary 4. Offices are on Sydenham 4 and Brock 4, the Brock 4 offices to be relocated on Centenary 4 after renovations now in progress.

At the March 9, 1989 meeting of the Board, the unit was named the Ivan T. Beck MD Gastroenterology Unit, and the research unit the Ivan T. Beck MD Gastrointestinal Diseases Research Unit. They were officially inaugurated by Ontario Premier David Peterson.

From its beginning the division was rated as among the best in Canada in terms of its close cooperation between basic scientists and clinicians, involving research collaboration with a number of other Queen's departments.

The future could easily bring an amalgamation of those practising gastroenterology into a digestive diseases referral centre including all the pathologists, radiologists and support services necessary for such a group, an expansion of the Digestive Diseases Group. Dr. Da Costa, current head of the division, would like to see the Digestive Diseases Group enlarge its mandate to include a nutrition program involving gastroenterologists, surgeons, paediatricians, nutritionists, dietitians and nurses. A regional swallowing disorders centre could build on the area of strength of the already existing swallowing disorders group which has one of the most sophisticated laboratories in Canada for the investigation of gastrointestinal tract motility disorders, particularly esophageal motility and anorectal disorders. Also under consideration is a regional inflammatory bowel diseases unit, to comprise a medical/surgical team that could provide integrated patient care. The division could easily be expanded in future to form a regional hepatology unit, since it already has two of the best hepatologists in Canada. The unit would look at patients with severe hepatocellular problems, serve as a referral centre to centres that perform liver transplants, and provide postoperative care.

From the days of Eleanor Whalen, the first head nurse, one of the prides of the division has been the nurses who provide the patient care: specially trained, knowledgeable and able

to ensure that the patient on the unit always understands what is happening.

GENERAL INTERNAL MEDICINE

In 1993, to meet the need for more general internists in Canada, a division of general internal medicine was established. Located at HDH, it includes inpatient and outpatient services as well as providing a consultative service to KGH and St. Mary's of the Lake.

The program director, Dr. Don Farquhar, will emphasize ambulatory care, teaching and the management of general medical patients. Training in general internal medicine is offered to both undergraduate and graduate students, with undergraduates gaining practical experience at bedsides and in general medicine clinics. Plans are under way for fellowship positions as well as a research component, concentrating on the measurement and evaluation of health care outcome. Residents will be trained for private practice as well as for roles in small to medium-sized hospitals in Canada.

The department plans to develop strong relationships with geriatrics, psychiatry and family medicine to provide the best combinations of teaching opportunities and service to meet the needs of patients in both general and specialized clinics as well as inpatient services. A future rapid consultation clinic could take some of the pressure from the Emergency department. Previously split between HDH and KGH, internists in the Internal Medicine department include Dr. Edward Gibson, Dr. Andrew Koval and Dr. M. John B. Stalker.

GERIATRIC ASSESSMENT UNIT

In the late 1980s the Ministry of Health announced a $3.2 million grant to establish a Geriatric Assessment Program for southeast Ontario, one component of a program to assist the elderly to live independently in their own community.

The program will provide assessment, referral and outreach services for those needing complex geriatric care. Planned is a 10-bed inpatient unit on Jeanne Mance 4. St. Mary's of the Lake Hospital will provide an expanded day hospital with eight short-term assessment places and 14 intermediate-stay rehabilitation spots, an expanded outpatient clinic and consultation

services with satellite outreach services. With all outpatient activity taking place at St. Mary's of the Lake, the major focus at HDH will be on inpatient assessment. The new unit will provide educational opportunities for health care professionals, patients and their families about the treatment of the elderly.

The St. Mary's part of the program is already in full operation. HDH's contribution of the inpatient unit will be provided through the current Healthcare 2000 fundraising campaign.

NATIVE PATIENT SERVICES

Cultural interpreters who not only speak the language but know the culture and are able to negotiate and provide friendship in a strange city are very important. Native Patient Services began in 1985 with a one-year contract from the Department of Employment and Immigration to hire native people in the Kingston area. The resources were used to start a pilot project to improve the quality of health care delivered to Cree-speaking patients from James Bay. Also involved was Geaganano Residence, described under the Outreach section of the book. In February 1986 the two services were combined under the title Native Patient Services.

Native Patient Services provides administration, translation and basic counselling, and does all admission and discharge planning for the James Bay Cree, as well as arranging all local transportation and appointments, under a Cree-speaking assistant coordinator. Cree translators are mainly recruited from the Ottawa, Timmins and Cochrane areas, which are more closely linked to the Cree culture. Currently there are two full-time interpreters who can deal with the three dialects spoken on the west coast of James Bay. Two of the dialects are quite similar, the third somewhat further apart. Members of the three dialect groups can understand each other socially, but translation is needed for the intricacies of medical interpretation.

When the service first started, there were 200 status native patients in contact with the department. In 1993, there were 803. That first year 43 family members were funded by Moose Factory General Hospital to come to Kingston, and by 1993 the numbers had grown to 478. Geaganano is full all the time with family members and outpatients, and the overflow is housed in a local hotel. The Services are geared mainly for Cree-speaking patients but provide unofficial liaison with those from

other nations. A few Mohawk patients also arrive at the Hospital, and Micmac from the east coast and some members of tribes from the Northwest Territories have also received treatment.

At first, plane service to Moose Factory was limited to one plane every two weeks, carrying medical staff up to the General Hospital and patients and family down to Kingston. Now, it has expanded to three times a week.

It can be a terrible cultural shock to arrive from isolated communities with no running water and where daily living is very difficult. Midge Rouse, in charge of the Services, says that success working with people from other cultures comes when they start to share their humour, and can tease and be teased without offence. One client became very amused at the need for a wide range of identity cards. In his isolated community, everybody knew him. In Kingston, he was overwhelmed by the number of cards that he needed: his health card to obtain his "blue" card used at both Kingston hospitals, and his status card for prescriptions. After a round of outpatient appointments and demands for cards, he told Midge, "You know, when I get home I'm going to tell my children that I went to the bathroom down here and I used the toilet but before I was allowed to flush the toilet a voice said, 'You have to show me your card.'"

No other Native Patient Service functions like HDH's. It was started in the south by non-native people for native clients, which now might perhaps not be politically acceptable; but there were no Cree people in Kingston to ask for these Services. It was the vision of the Sisters that saw the importance of outreach to the north, and provided the space and the support for this unique program.

NUTRITION SERVICES

Early Hospital meal preparation was supervised by the housekeeper or the nursing department. But it rapidly became apparent that help was needed from people trained in foods and nutrition, and today hospitals include dietitians. One dietitian, Mary McLean, began work in 1946, and has memories of those more formal days. "The butter was put out on little china patties for each meal. The Sisters all had their little kitchens, and some of the private rooms got their own cups and saucers and their own little salt and pepper shakers and their silver tea services."

The diets being offered have changed as well over the years, from meat, potatoes and vegetables to menus including pastas and quiche. Workloads have also changed. "When I first went there I was doing everything. We would have students in the department for six weeks at a time working on diets and food preparation and that sort of thing, and I was teaching them. If the baker didn't happen to come in, I made the desserts. If the pot washer hadn't been there and the pots were still there in the middle of the night I would do those."

Photo by Wallace Berry

Sister Elizabeth Rouble, Chief Nutritionist, with patient, 1960.

She still remembers the Hospital's Christmas celebrations. "In those days we used to have a Christmas banquet for every group, and two weeks before Christmas there were banquets after banquets after banquets. When we had our banquet, the office staff and the administration came down and served us and ran the dish machine and did everything. I can still see Eric

Brown, the administrator at that time, running the dish machine. It was a wonderful place to work."

OBSTETRICS AND GYNAECOLOGY

In the 19th century, when most deliveries occurred at home with an attending family physician and/or midwife, HDH provided obstetric service mainly for emergencies and complications. Family physicians and general surgeons performed gynaecologic surgery. In 1889 the only female physician at HDH, Dr. Isobel McConville, was an obstetrics specialist, but there was as yet no structured department.

The 1902 "4th agreement" with Queen's which opened wards and the operating room to Queen's medical faculty for teaching introduced clinical instruction on gynaecological patients at HDH; shortly after World War I, it was formally established as a clinical department. In May 1910 a maternity unit was opened, appropriately enough in the former orphanage on Sydenham 5 (now the Fitness Centre), and managed 30 deliveries in its first year. By 1916 deliveries had doubled to 73 (carefully separated by sex in the Annual Report) and again to 183 in 1930.

There were two women in Kingston in the 1920s who made a practice of attending mothers in childbirth in the general community. "They were both big women," said Dr. Fergus O'Connor Sr., "big capable women. The only trouble was that I think they really rather enjoyed it if the baby was born before the doctor arrived. Sometimes they left it until the very last minute before calling you."

The Sisters always found maternity and neonatal work particularly satisfying, but it was not until 1930 that Archbishop O'Brien allowed the first, Sister St. Mary Magdalen, to be present at deliveries. The Sisters went on to meet the challenges of advancing technology and increased specialization. Sisters Veronica Callaghan and Mary McDonald, for example, left HDH for six months in 1940 to take post-graduate obstetrics courses at Royal Victoria Hospital, Montreal.

In the early 1940s, at first the Queen's medical school sent its fifth-year students for one week's training in obstetrics to London, Hamilton and Toronto. Students were lucky to see one patient. Arrangements with HDH soon let fifth-year students obtain a week's obstetrical training, living in and as "shadows"

observing about 25 patients. In 1955, in a move encouraged by the Sisters, the Department became fully affiliated with Queen's; by 1961 deliveries averaged three per day and the Department (under Drs. Gordon R.W. Mylkes and Lawrence N. O'Connor) had to divide the hitherto combined Obstetrics and Gynaecology outpatient clinic to allow more teaching time. In 1963 it acquired new premises on Centenary 3 and 5, and on Johnson 5 in 1965, with a complete modern delivery suite, doctors' quarters, and (an innovation by Sister Dorothy McParland) a waiting-room for fathers, who could now assist at their children's births.

By 1969, the Department of Obstetrics and Gynaecology, under Dr. John A. Carmichael, had grown to become one of the main clinical departments. Despite a drop in the general birth-rate, about 1,000 mothers per year benefitted from these facilities, while the gynaecology ward admitted over 700 patients annually for about 500 gynaecological surgical procedures. The department also had major responsibilities for both undergraduate and graduate training, and several clinical investigation programs were instituted.

It was therefore a harsh stroke of irony that the department's busiest year ever, 1970 (with 1,118 deliveries and 829 gynaecology cases) was also the year in which QUAFHOP began its rationalization process, and the Catholic Hospital Association of Canada issued its edict prohibiting abortions, tubal ligations and contraception advice. It was thus impossible to establish a consolidated obstetrical department offering these services at HDH. The decision to move Obstetrics completely to KGH was formally announced on December 28, 1972. On April 1, 1973, the maternity unit and nurseries closed at HDH forever, leaving a deep sense of loss in Sisters, staff and the Kingston community. Gynaecology continued at HDH for another ten years, and one weekly outpatient clinic ran until 1993. All services and program teaching are now at KGH.

OPHTHALMOLOGY

Although ophthalmologic services attracting patients from long distances were offered by Dr. C.E. O'Connor in the early 1900s, and after him by Dr. Thomas F. Rutherford, the department itself is relatively new, inaugurated at Queen's and KGH in the early 1960s. It conducts research in the field of contact lenses and external diseases, and offers services at both

hospitals. At HDH, although Dr. John Morgan has now retired, Dr. Wendell E. Willis provides services in general adult and paediatric ophthalmology, surgery on the front of the eye, contact lens care, treatment for diseases of the external eye, and ultrasound testing.

The department offers a strong residency program with six positions; and an integrated program between the two hospitals is being developed to consolidate undergraduate and postgraduate training and to ensure there is no duplication of facilities, equipment and specialized services. The department provides virtually all of the tertiary specialized care in the region, and most of the secondary care in the western part since Belleville no longer has an ophthalmologist.

The department would like to see the establishment of an Eye Institute, probably at Kingston General Hospital. Medical links with the neurosciences, endocrinology, rheumatology and immunology are strong — these are areas of consultation.

ORTHOPAEDIC SURGERY

When HDH was founded there were no x-rays or anaesthetics for fractures, and broken bones were splinted with pieces of wood and strips of cloth or bandages hardened by egg white. In the latter half of the 19th century, a patient arriving at HDH with a broken bone or dislocated shoulder would likely have suffered the injury a few days previously. Muscular passers-by would be conscripted and asked to pull on the bone or joint, and treatment would also probably have included warm bran poultices. Once the joint was back in place or the broken bone looked normal — and this could have taken several days without anaesthetic — the limb would be strapped between wooden splints. Often, the injured part was hammered to loosen the inflamed tissues and promote healing. Since bones were kept splinted for long periods of time, the result was stiffened or withered limbs.

By 1857, a method of applying traction tapes to the leg was described. During the building of the Mersey Canal near Liverpool, the Thomas splint was developed, while the first overhead beams on hospital beds were used during the 1903 Balkan wars, and the development of x-rays, described under Radiology, enabled broken bones to be repaired accurately.

Before the 1950s, orthopaedic surgery was performed by such general surgeons as Dr. Duncan Boucher (1928-1976). The first orthopaedic surgeons, Dr. James Melvin and Dr. John Hazlett, provided service in both hospitals during the late 1950s, as well as hospitals in Belleville, Trenton, Smiths Falls, Brockville and Picton. At that time there were no designated orthopaedic beds. Dr. Charles Sorbie succeeded Dr. Melvin as the first joint Head. The first designation of beds for orthopaedics was made with the establishment of clinical teaching units in the early 1960s. On April 18, 1963, a new orthopaedic unit opened, a 16-bed area in the original Brock 5 delivery room area.

Today, orthopaedic surgery is significantly different to that practiced 25 or 30 years ago. Antibiotics have allowed surgical intervention for many things not possible in the past. Following the Second World War when penicillin became universally available, the death rate from osteomyelitis, formerly extremely high, has approached zero.

Total joint replacement, specifically total hip replacement and total knee replacement, have become some of the most commonly performed procedures in all of surgery. The first joint replacement operation done in Kingston was performed during the 1960s. Fusion of destroyed joints was then the method of choice.

The first prostheses were one-size-fits-all and were cemented into place. At first, some failed, and it was thought that the failure was due to the cement. Prostheses were then developed that used a roughened metal surface into which the bone grows, but they too failed. The cause may stem from wear in the polyethylene liner used in the joint. In spite of this problem, today the long-term prognosis for joint replacement is very good.

The greatest challenge in orthopaedics is the multiple-injury patient from motor vehicle accidents, with many broken bones, roadside contamination of tissues and possibly parts of missing bone. "Trying to put Humpty Dumpty together again so that they are able to walk and function normally is certainly without question the greatest challenge still and the greatest ultimate reward for the orthopaedic surgeon," says Dr. Don Taylor.

New Swiss-developed methods of fixation of broken bones now provide better fit and much stronger fixation than ever; and

improvement in intermedullary fixation, the placing of a rod down inside a bone, has helped change the orthopaedic world. There is also great interest in new and different ways of reconstructing ligaments in the knee and in other soft tissue operations about the joints.

Outpatient surgery at HDH suddenly took on a new importance following the fire on November 7, 1967, when almost all the orthopaedic beds were lost. Colonel Fitzgerald, the officer commanding the Armed Forces Hospital on Highway 15, offered the use of his facilities; and orthopaedic treatment took place in that hospital for at least six months after the fire. Eventually, the orthopaedic patients were resettled on Brock 3.

This also helped trigger the development of outpatient orthopaedic surgery at HDH, which for some time, helped by the development of arthroscopy, was at the cutting edge of this technique in North America. In 1973 HDH began to provide this diagnostic procedure, arthroscopy, which lets a surgeon see the internal structures in the joint through a small incision. The procedure was performed for the most part on an outpatient basis, under general anaesthesia. Equipment provided by donations from the Volunteer Services and the Department of Medicine in 1984-85 let the procedure expand from diagnosis to treatment. Surgical procedures such as joint debridement to smooth rough surfaces and remove cartilage fragments probably caused by arthritis or trauma could now be done without an overnight stay in the Hospital.

Dr. M. Anthony Ashworth came to Kingston in 1968 as the first children's orthopaedic surgeon, and with the move of paediatrics to the new Jeanne Mance wing came on staff at HDH. The staff continued to grow: a second children's orthopaedic surgeon arrived, Dr. Douglas Hedden, replaced in 1994 by Dr. Lindsay Davidson; and Dr. John F. Rudan, a dedicated adult orthopaedic surgeon, mainly interested in adult reconstruction of joints. Dr. David Pichora, who functions from KGH, has a special interest in hand surgery and holds a one-day-a-week clinic at HDH.

HDH's orthopaedic unit, however, is not all things to all orthopaedic patients. Multiple trauma and spinal cord injury are managed at KGH. HDH's patients are usually those with less extensive injuries — older patients with fractured hips, patients with fractured legs, and all paediatric work following stabilization for multiple trauma at KGH, if necessary. Much

reconstructive surgery is also performed at HDH. Orthopaedics also plays an important training role for medical students, with both undergraduates and some postgraduates learning orthopaedic techniques at HDH as well as at KGH. Two enter the three-year program annually as Fellows. There are resident rotations in surgery and family medicine which emphasize emergency and ward care. Family medicine residents are assigned to as many clinics as possible to learn outpatient management.

Further rationalization of services, especially in orthopaedics, is now being discussed, says Dr. Ashworth.

OTOLARYNGOLOGY

In the 1930s and 1940s the specialists were eye, ear nose and throat doctors, although surgery of the eye had not developed extensively. People did not have operations for cataracts. The majority of the diseases looked after had to do with infection, and infection in the sinuses as it related to the eyes. The surgeons involved because of their location and because of the pathology that surrounded it were notable specialists, including Dr. F.X. O'Connor, Dr. Tim Rutherford and Dr. J. Gilbert McBroom. In Kingston the specialties split in 1960, with the creation of a department of Otolaryngology and a department of Ophthalmology, although at that time there were a number of staff members who did both. For many years there were otolaryngology patients in both KGH and HDH, and the bulk of the surgeons doing the work were eye, ear, nose and throat doctors.

The first surgeon specializing in ear, nose and throat surgery in Kingston, Dr. Jim Purvis, arrived in 1958 and worked mainly at KGH. A second, Dr. Donald G. Hooper, followed in 1964, working mainly at HDH and bringing the specialty and technology of ear surgery to Kingston, including the first operating microscope (now used by many specialties). Clinical audiology or hearing testing also arrived at the time.

Two other otolaryngologists, Dr. Malcolm Williams and Dr. Ljubo Vukovic, followed; and Dr. Stephen Hall, the current department head, arrived when construction of the Murray building was almost complete. He considers the building a magnificent facility, the envy of every ear, nose and throat department in the country. The building once housed the Human Communications Unit, now discontinued, and still houses the ear, nose and throat department, clinical offices and Queen's

administrative offices, the clinic facility, and all the audiology system for the city and region.

Today, five out of seven otolaryngologists practice in the building. There is now no graduate-level teaching, although there was a residency training program in ear, nose and throat in the mid-70s. All the undergraduate education is done during the outpatient teaching clinics, teaching clinical skills in family medicine, paediatrics, medicine and emergency medicine to third-year students and fourth-year clinical clerks. One resident from Family Medicine is also assigned to the program.

The department conducts work in audiology, hearing testing and rehabilitation of the hearing-impaired, and also holds a number of specialty clinics in the Murray building, many multidisciplinary.

The voice-disorders clinic involves speech-therapy experts, psychologists, and often someone from community singing groups. They see a whole spectrum of patients with voice disorders, from the man on the street to professional talkers such as teachers, preachers and singers. A multidisciplinary hearing-impaired clinic is mainly for children with difficulties that accompany their hearing problems. They are seen by the paediatrician, the audiologists and the ear, nose, and throat doctor, and on occasion a social worker. An important "funnel" clinic for the entire district is the facial anomalies clinic, again multidisciplinary, for children with malformations which result in a variety of problems. They are seen by the ear, nose and throat staff, by audiology, by paediatrics, and by a plastic surgeon, a dentist, and often an orthodontist. A clinic, started by Dr. Hall, sees patients with dizziness. Vestibular-test facilities test people's balance.

The head and neck cancer clinic, located at the KGH cancer clinic because geographically that is where the patients are, is considered one of the HDH subspecialty clinics within the network of the ear, nose and throat department.

The outpatient facility is considered to be one of the best in Canada. Current plans include the development of an adult short-stay clinic and possible outreach clinics in the Napanee, Perth and Smiths Falls areas.

PAEDIATRICS

Children suffering from measles, diphtheria, scarlet fever, typhoid fever, smallpox, and even cholera were treated at HDH from the beginning, by the attending doctor and later, by family physicians. Obstetricians cared for the newborn. Dr. Fergus O'Connor Jr. was the first paediatrician involved in the development of the specialty within HDH, ably assisted by Sister Teresa Baker. When the paediatric beds opened in 1941, the Hospital had no funds for instruments and equipment and he had to supply his own. He remembers treating scurvy with diluted orange juice, and bacterial meningitis with IV sulphathiazole, curing patients who previously would invariably have died. During the 1950s and 1960s paediatric patients were loved to wellness by Sister Margaret Mary MacDonald, the "praying nun".

Paediatric units at the two hospitals amalgamated, the department moved to KGH in 1977, and between 1977 and 1984 paediatrics, including newborn care, was entirely at KGH. On June 30, 1984 all paediatric care, apart from newborn and premature care, genetics, cardiovascular and chest surgery and neurosurgery, transferred to HDH under joint Chief Dr. Nuala Kenny, a Sister of Charity of Halifax. The Hospital now delivers 96 percent of all paediatric care in the area. Its outpatient services include primary care, medical and surgery clinics, and care for the developmentally handicapped.

Paediatrics now consists of the outpatient facility, a paediatric inpatient ward on Jeanne Mance 3, a five-bed paediatric intensive-care unit, and a 10-bed paediatric short-stay unit. At one time there were 80 paediatric beds on four floors at KGH; and the equivalent of 50 beds at HDH. Today, with modern medical techniques, antibiotics, newer approaches, shorter hospital stay and much more ambulatory paediatrics, the need for massive numbers of beds is gone. Part of the intensive care area includes two "care-by-parent" rooms for families of children who are critically ill and undergoing treatment.

There are two other major foci for paediatric care at HDH. The Children's Outpatient Centre on Jeanne Mance 1 consists of a large ambulatory clinic including examination suites, treatment and plaster rooms, an observation area and a large waiting and reception area, as well as offices and interview rooms for quiet consultation on psychiatric problems and child abuse. The

Centre opened as a separate ambulatory area in the Angada wing of KGH in 1970 and subsequently moved to HDH in 1984.

The Child Development Centre, established as the Regional Centre for Handicapped Children in 1973 and initially located in Nickel wing at KGH, was the province's first assessment and treatment centre for children with disabilities to be incorporated in a general hospital. It also moved to HDH in 1984, and is a regional centre for the assessment and management of physically multi-handicapped youngsters. It diagnoses and treats children from birth to 19 years of age with emotional, physical and perceptual handicaps; and together with the Children's Outpatient Centre it runs, organizes, and coordinates special programs for children with chronic problems.

One unique program introduced handicapped children to horses at a local riding facility, Tiny Myering Disabled Riding. Riding can improve and strengthen the coordination of muscles needed to control the head and trunk, and gives the child both a social outing and an independence not available in other activities. A special ramp was designed by local engineer Peter Balson with donated materials. Volunteers from Alcan and inmates from Frontenac Institution, a local minimum-security prison, built the ramp to make it easier for the staff and the physically handicapped riders to mount the horses.

Paediatrics also operates a walk-in general clinic on weekdays, and there is always a paediatrician on duty in the Children's Outpatient Centre.

Operating out of or associated with this Centre are eighteen sub-specialty clinics, including paediatric cardiology, neurology, haematology/oncology, facial anomaly, spina bifida, hearing impairment and intestinal disorders. The Centre also offers a program for cleft lip and cleft palate, and there are even a seating clinic for children needing wheelchairs or other special equipment, and a feeding clinic for children with feeding disorders. The Centre treats as well, children with infectious diseases, respirology problems or cystic fibrosis. Although there is not a separate child-psychiatry inpatient unit there are always four or five psychiatric children patients on Jeanne Mance 3 and there is a secure room for children whose behaviour is difficult. Paediatricians, child psychiatrists, nurses and social workers, and representatives from the Emergency department, operating out of the Children's Outpatient Centre, comprise a child

abuse/sexual abuse team, all part of the child-protection initiative.

The department has 12 full-time paediatricians associated with it, the majority of whom work at HDH. Other divisions such as otolaryngology and audiology are also heavily involved with paediatric care, as are gastroenterologists, child psychiatrists, physiotherapists and occupational therapists, general surgeons, orthopaedic, plastic, and ophthalmology surgeons and a wide range of other specialists also play an important role. The department of nutrition deals with the nutritional challenges of children who have intestinal disorders, premature babies who have not developed feeding approaches, and handicapped children with cerebral palsy or developmental disability who do not feed well. There are also 10 paediatricians in the community, all with privileges at HDH.

The division acts as the tertiary-care centre for the region in southeastern Ontario, and critically ill children from Brockville, Belleville, Napanee, Picton and Trenton, and a few from Perth and Smiths Falls are transferred to HDH. Paediatrics has developed a transport team of paediatric residents and respiratory therapists able to go out with helicopters or land transport and bring children back to HDH.

The future for paediatrics at HDH looks bright, says head Dr. Brian Wherrett. "For the immediate and the extended future there's a clear commitment for the main base of paediatrics to stay at the Hotel Dieu."

The paediatric postgraduate program began in 1959 with HDH involved from the very first, and provides a comprehensive and integrated program over two sites. "The reason why paediatrics is so well suited to this setting is that our education mission is the training of undifferentiated medical students in paediatric general care, our main mission in undergraduate medical education."

The future includes possible alliances with the Children's Hospital of Eastern Ontario, University of Ottawa, University of Toronto, and the Sick Children's Hospital, to establish an associated residency program.

Paediatrics also plays a role in continuing medical education, through the Queen's programs for family physicians and paediatricians; and provides outreach training to regional centres.

The **Child Life Program** is a totally independent program, but works closely with the paediatrics division to help children communicate their anxieties and fears resulting from medical visits and hospitalization. Staff encourage the children to express their fears through creative arts such as painting, drawing pictures, acting out stories and playing musical instruments. The program also works closely with the Native Patient Services Program. The need for such help can be great. Records report that one little girl from the James Bay area who could speak only Cree began to draw a grave with a cross on it. With the help of translation services, the staff realized that the little girl thought she was going to die. After reassurance and explanation, she soon realized she would be going home again.

The Child Life Program later established an art therapy program for emotionally distraught children suffering stressful and lengthy treatment. It recently received a special puppet from St. Paul the Apostle Knights of Columbus. Named "Ruth" by one of the patients, she joins "Ralph" as part of the paraphernalia used in discussing a child's treatment, fears and concerns. "Ruth" came equipped with two wigs, one patchy for use with children receiving chemotherapy. She has a spine on which lumbar punctures can be demonstrated; veins for IVs and a pin for her knee to demonstrate orthopaedic treatment. She can also spit and cry — with some help from the puppeteer.

PALLIATIVE CARE SERVICE

In existence since the founding of HDH, a formal palliative care service was established in 1987. Dr. Janet Sorbie and Dr. Neil Hobbs of the Family Medicine Centre were among the first from HDH to sign on, and are still members, as are four other family physicians on the multi-disciplinary team, which also includes a nutritionist, a pharmacist, and representatives from Pastoral Care, Home Care and Hospice Kingston.
Headed by Dr. Wes Boston, Head of Queen's Palliative Care, the physicians involved are mainly concerned with symptom control and relief, the comfort of the patient, and personal counselling of patient and family. House staff rotating through the services in the Hospital are also educated in the principles of palliative care — decreasing or stopping the number of lab tests, adoption of less aggressive treatment, and making patients comfortable for their remaining days.

The service, although still "invisible" according to Dr. Sorbie, has made progress in five years. It is receiving more referrals and is known to far more people.

PATHOLOGY SERVICES

Pathology is the truth centre of a hospital. HDH has had very conscientious pathologists, including Dr. John Tweddell, Dr. Fred Howatt and Dr. Douglas Waugh, followed by Dr. T. Frank McElligott.

Twenty-five years ago laboratory testing was scanty and very labour-intensive. With increasing knowledge of biochemistry, haematology, histology and a wide array of other medical "—ologies", the hospital laboratory now plays a vital role in providing the information on which many diagnoses and treatments are based.

In the 1950s, the medical laboratories were located in the basement of Centenary, with rooms for chemistry, haematology, urinalysis, histology, microbiology, and records, which were then transcribed by hand onto a form which was pasted to the patient's chart. The Sister in charge oversaw four technologists, the medical and technology students, and a secretary. A pathologist was also on staff. By 1992 the staff had grown to five technologists and a clerk in Haematology, about five other pathologists, about seven technologists in Biochemistry, eight technologists in Microbiology, about four in Histology and two in Cytology, a relatively new discipline which studies the components of cells and which did not exist at HDH in the 1950s.

One unchanging component of the labs was — change: changes in types of tests done, equipment used to perform those tests, and the explosion of interpretive technology.

When the Johnson wing opened in 1966 the labs moved to Johnson 2, later renovated in the early 1990s. The renovation addressed two major areas of concern: physical environment, and equipment. Over the years, as massive equipment came into the lab to perform tests more accurately, speedily and efficiently, the work space for the staff decreased to the point that for some it was the top of a deep freezer or a covered-over sink. Staff safety was compromised due to confined space, lack of proper ventilation, lack of appropriate biohazard material handling facilities, excessive noise and exposed wiring. Deteriorating equipment which required repeat tests and large numbers of control

samples further exacerbated the situation. On April 12, 1991, the go-ahead was received from the Ministry of Health for the renovations, at a cost of almost $4.3 million. Three essential new pieces of equipment were purchased: two analyzers for Clinical Chemistry and a cell counter for Haematology, all with the ability to interface with a new computer system that will eventually link all the laboratory services.

The personal computer-based system, one of only a few being used in a 24-hour-a-day tertiary-care teaching hospital, lets staff enter test data directly into the computer so it can be amalgamated into a patient report that is then sent to the patient care unit. The progress of individual patients can be followed easily, and eventually all records will go "on line." It is possible, too, that in the future the labs could be connected with departments such as Emergency or Admitting using the Hospital-wide computer network.

Six clinical labs were destined for refurbishing. Clinical Chemistry performs tests on blood serum. Such blood components as glucose, sodium, potassium and chloride are measured for possible abnormalities. A small amount of therapeutic drug monitoring to determine the best drug routine for a patient is also performed. Haematology performs most of the routine blood testing. Red and white cells, platelets and haemoglobin are counted or measured to help diagnose diseases such as anaemia and leukaemia. The lab also monitors the effectiveness of coagulation therapy. Every patient admitted, 125 to 150 per day, has a haemogram done by the Service. The Blood Bank stores blood and blood products for use during surgery, and orders needed products from the Red Cross Society in Ottawa. It runs tests such as cross-matching, working closely with Haematology. It provides a 24-hour-a-day lab service, as does Clinical Chemistry and Haematology. Microbiology is an interpretive area which studies micro-organisms such as bacteria and parasites. Its technicians look for organisms that could be causing a particular infection or ailment in specimens provided by physicians. They also perform tests to determine whether a particular antibiotic will combat the organism. The Cytology lab studies cells in both gynaecological and non-gynaecological specimens. The majority of work involves Pap smears, sent in from physicians in the area. It also studies urines, sputum, fluids and brushings, looking for malignant cells. Finally, in Histology, a service related to Pathology, tissue samples from surgery are embedded in wax,

thinly sliced, and studied under the microscope by a pathologist. These clinical labs were officially opened and re-dedicated to Dr. T.F. McElligott in March 1993.

Patient contact also changed over the years. In the 1950s technologists and student technologists took all blood samples. Later, a special phlebotomy team was formed to perform this duty, and although today's work is much more sophisticated and much more accurate, staff still miss that close patient contact.

The department of Pathology is extensively involved in teaching at the undergraduate and postgraduate level, service, and research. It provides the infection control in the Hospital, and the importance of its educational role has grown in recent years with infectious diseases such as AIDS and meningitis. For control of hospital-acquired infections such as post-operative wound infections, diarrhoea and pneumonias, compliance by all Hospital staff with infection control standards must be assured.

In 1984-85 the Department received a new system of equipment to perform blood examinations. Comparisons of specific blood components from a sample against normal ranges for sex and age can be made automatically. An alarm system alerts the technologist to any abnormality. The system can also count white blood cells differentially and prepare clear, concise and legible printed reports. A computer can store all the haematology results for each patient from admission to discharge, aiding in diagnosis and treatment.

PATIENTS FROM THE PRISONS

Although unofficially the Sisters have cared for inmates from local prisons since 1845, more recently sick and injured inmates were treated in a special secure wing at the Canadian Forces Hospital. On March 31, 1976 the Hospital was reduced to a 10-bed clinic, and was no longer able to take sick prisoners.

At one point the Correctional Service considered building its own hospital, and indeed a considerable sum was spent on infrastructure at the south end of the Collins Bay property, according to Ontario Deputy Commissioner Andrew Graham. "This was going to be both a mental and a physical hospital, but it suffered the consequences of one of the thousands of budget cuts that we have been experiencing over the years." Active consideration was given to purchasing the Canadian Forces Hospital, but this was rejected, and the Service approached the

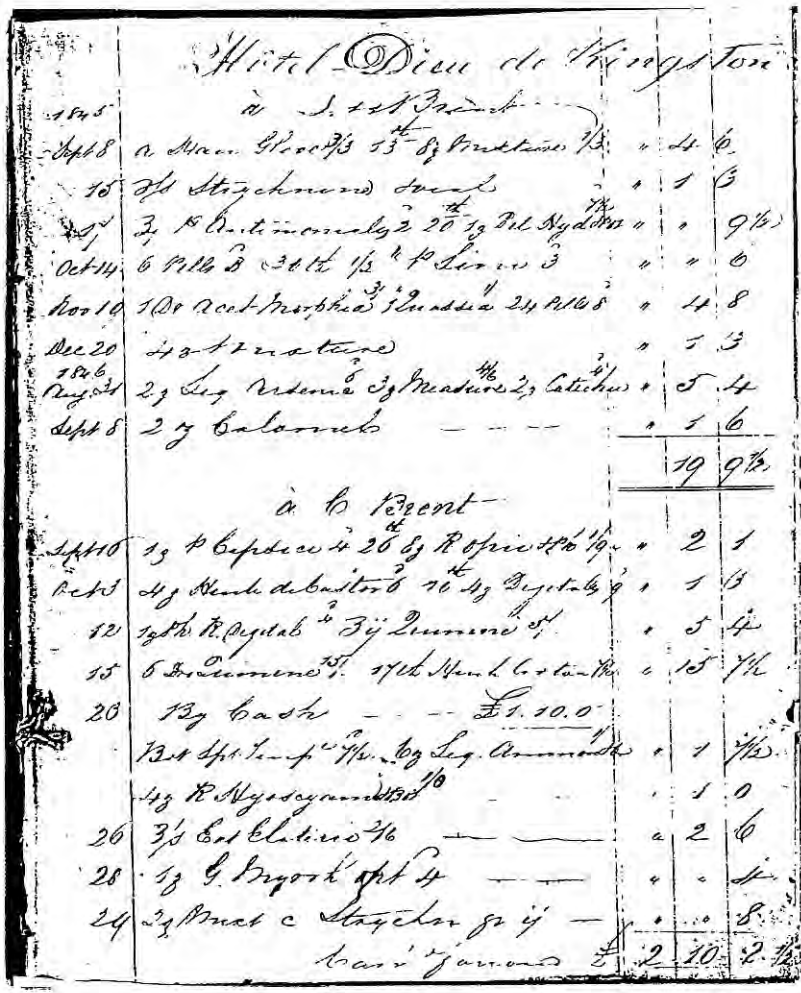
community hospitals, KGH and HDH, to provide inmate care. "There was more negative response from Kingston General about security concerns," said Dr. Don Workman, physician at Millhaven Institution. "Finally, it was agreed that Hotel Dieu would look after the bulk of the problems, and that Kingston General Hospital would take in those who simply needed the specialty services that weren't provided at Hotel Dieu. My understanding is that the Sisters said that Hotel Dieu is a community hospital but it is also affiliated with a religious Order which has a firm commitment to providing health care to those who need it."

Initial reaction about the arrangement among many at HDH, including the Volunteer Services, was negative, in part due to security concerns and in part due to image. It was disconcerting to a parent bringing a child with a sore throat to Emergency to find themselves beside an inmate in shackles surrounded by guards. Although nursing staff treat and care for inmates like any other patients, at times they have worries about security in terms of hostage taking and injury. Handling of inmates isn't easy, said Dr. Workman. "We have 600 patients here, the average age is certainly under 30, and no other community of 600 people would have as many people go to Emergency as ours, with injuries, wounds, stabbings, everything."

An inmate needing medical care is first assessed by Health Care at his institution. He is escorted by a specially trained regional escort team to a special holding area in the Hospital. If considered dangerous, he must also be cuffed and shackled. Once in Hospital the offender is guarded round the clock by the appropriate number of guards. HDH has had its share of notorious patients. The child killer, Clifford Olsen, has been treated on two occasions, once for stomach pains when an x-ray discovered he had concealed a handcuff key in his rectum. On the near horizon is a three-bed secure unit on Johnson 7, a $300,000 project being funded by Correctional Services.

PHARMACY

Drugs in 1845 were of either vegetable or mineral origin. Some still used today are magnesium sulphate or ferrous sulphate among the mineral-based drugs, and tincture of belladonna and tincture of opium among those of vegetable origin.



Courtesy of Religious Hospitallers of St. Joseph. St. Joseph Province Archives

Hotel Dieu Hospital Pharmacy accounts ledger, 1845.

The pharmacist lived in the pharmacy, and made almost all of her drugs from raw materials: stems, roots, leaves, bark, flowers. About half could be stored briefly for periods from a week to a year. The rest had to be prepared fresh. The pharmacist had to know how to extract the active drug from the raw materials, the proper order in which to add the various solvents, their strengths and temperatures, and chemical incompatibilities. There were no such aids as pills and vials. Powdered drugs

were provided in powder papers or cachets, or stuffed into gelatin capsules. To make sure that dosage was accurate, each powder had to be weighed separately, then mixed and weighed again.

Modern drugs did not arrive until the mid-1900s. Today's pharmacy at HDH, and the role of the pharmacists, bear little resemblance to those of the first Sister Pharmacienne in 1845, or even to those of the pharmacists 100 years later. Even in 1945, the practice of pharmacy was primarily related to responding to the order of the physician in preparing the medication. Mother Mary Murphy, followed by Sister Margaret Morrisey, dispensed drugs to patients and taught Materia Medica to nursing students.

For many years the Hospital used a traditional drug distribution system, similar to that of a local pharmacy, in which about a five-day supply of medication is prepared and dispensed. In the late 1960s and early 1970s, particularly in the United States, a unit dose system of medication was evolving.

The practice of pharmacy has also changed over the last 15 years or so. Pharmacy now has become much more focused on meeting the pharmaceutical needs of the patient rather than on the drug, and the pharmacist has resumed active membership in the health-care team.

It is not all paperwork, of course. With a much wider range of methods of administering medication, the pharmacist now prepares the solutions for total parenteral nutrition for patients who can't eat, the syringes used for patient-controlled analgesics in "pain pumps", the special dosages for paediatric patients, and the specialized medications used in chemotherapy. Today's pharmacists also provide clinical services. Each pharmacist at HDH is associated with a nursing unit or two, and visits those units at least three times a week reviewing drug therapies. "We have a dual role," says director of Pharmacy Janice Wells. "We make sure that everything is there on behalf of the patient, but also we have a responsibility administratively in making sure that we're using resources in terms of money wisely. It would be inconceivable for us to stock every drug on the market."

Hospital pharmacists also participate in the Pharmacy and Therapeutics Committee, a subcommittee of the Medical Advisory Committee, and liaise with the medical staff about drug usage and drug prescribing.

In September 1992 the dispensing of medications at HDH became computerized, with medications and patient histories kept on a computer, and a special program added that draws the pharmacist's attention to the possibility of drug interactions, or prescription of more than one drug from the same drug group. The computer also permits analysis of drug use in the Hospital.

Today's formulary comprises about 1,100 items, including all the different dosage strengths of the approximately 600 drugs kept on hand. The formulary contents include a living animal component. Resident in a special refrigerator are about 80 medicinal leeches, stored in a solution of salt and water. The HDH pharmacy fills or refills about 65,000 prescriptions per year, prepares 1,800 bags of parenteral feeding solution, and about 500 chemotherapy doses every year. Thanks in part to computerization alerts, it has made about 2,000 recommendations and about 4,000 follow-ups of potential problems. And about one-third of their recommendations in one way or another achieve some drug cost savings as well as ensuring improved patient care.

In the future, Director Wells would like to see support available for the pharmacy to advance into the unit dose system, and into an intravenous additive system in which the pharmacy prepares all solutions for delivery to the nursing units. She would like the ability to link up with other computers in the Hospital, and to prepare some of the records by computer that are now being prepared manually by the nursing staff.

PLASTIC SURGERY

The department deals with the restoration or reconstruction of body structures damaged by injury or disease or which are not functioning. Located at HDH under the leadership of Dr. Patrick Shoemaker, it provides consultative services at KGH to both inpatients and outpatients. The two-bed burn unit, described earlier, is one of only eight such facilities in the province, and is a major user of plastic surgery techniques.

Although the program is not certified to train residents in plastic surgery, it is one of the most popular rotations for fourth-year medical students and residents in orthopaedic surgery and family medicine.

About 20 percent of the patients are admitted for breast procedures. Although the service has been asked to provide

on-site clinics to the referring hospitals, with the existing staff complement of only three plastic surgeons this is not possible.

PSYCHIATRY

At one time, the mentally ill were kept chained in asylums where they were beaten, degraded and deprived. The first chains were removed at the beginning of the 19th century by Pinel in Paris, and the first attempt at rationally classifying mental illness was made in Italy. Psychiatry and mental health clinics were only a distant dream.

There were not even enough insane asylums. Rockwood, now part of Kingston Psychiatric Hospital, was not built until 1866, and in the meantime the mentally ill were kept in local jails and in Kingston Penitentiary. Floor plans of the penitentiary as insane asylum still exist.

Concepts and diagnosis of mental illness have changed dramatically over the last 100 years. In the past, illnesses associated with old age were less common, since very few survived to old age. Diseases such as syphilic insanity and others caused by infections of the central nervous system were more common in the days before antibiotics. Hysteria also was probably more common, and probably misdiagnosed as some physical illness. There may not have been psychiatry as such in HDH's early days, but there were certainly patients with emotional and physical problems who were hospitalized on general medicine wards. Treatment of mental illness was as primitive as diagnosis, although electroshock therapy was introduced in the 1930s. Although the mentally ill at HDH were fortunate enough to receive kindness and consideration, only crude sedatives were available. Today's extensive synthetic pharmacopoeia of psychotropic medicines did not exist.

Limited clinic and inpatient service had been offered on St. Michael's Corridor since 1963. In 1966 the department of Psychiatry opened a psychiatric service with associated outpatient clinic and facilities on Centenary 5, under Dr. Tony Ives. By 1970, treatment facilities included individual and group psychotherapy, drug treatment, behaviour therapy and electroconvulsive treatment. This latter technique lost favour in the medical community for a time but has since been reinstated to accelerate treatment.

Dr. Ted Waring, the current Head, came to the Hospital in November 1990 when there were only four psychiatrists at HDH. With the rationalization of services, the department of Psychiatry has slowly been moving over from KGH, to occupy eventually the entire fifth floors of Johnson, Sydenham, Brock and Jeanne Mance. The service now provides primary, secondary and tertiary care on an elective or emergency basis.

There were, Dr. Waring thinks, possibly three reasons for the move to HDH. First was cost - it was probably less expensive to have certain departments in one place. Second, the department relates "more to the departments of paediatrics, family medicine, general medicine and general surgery than to the high technology direction of Kingston General Hospital. The third thing is that I think that the compassion of the Sisters and the administration and the history of Hotel Dieu of being willing to look after patients who are stigmatized makes the care for psychiatric patients here a positive step."

The department currently has four divisions: forensic and correctional psychiatric, the biggest and highest profile division; child psychiatry; developmental disability; and geriatric psychiatry. All are represented at HDH, but some are in fact services provided elsewhere. The forensic and correctional division is mainly provided in the prison system itself and at Kingston Psychiatric Hospital. Most of the resources for geriatric psychiatry are provided at Kingston Psychiatric Hospital. The developmental disabilities division is actually out in the community but will be moving to HDH. Some child psychiatry is at the Hospital and some in the community, in places like Beechgrove.

There are 19 residents in the program, and at times a physician with a fellowship. Seventy-two medical students rotate through the program as well, and the department also contributes to the Continuing Medical Education program at Queen's. The department is playing an important role in training family practice physicians, in cooperation with the department of Family Medicine. In one of the biggest changes in medical education in the last 20 years, all of the family practice residents are trained to detect and treat psychiatric problems in their practices.

Dr. Waring is delighted that 20 percent of the Healthcare 2000 fundraising goal is dedicated to the department of Psychiatry. "It's the first time in Canada to my knowledge that a fundraising program for general hospitals has dedicated money

to be raised for the department of Psychiatry." The funds will be used for providing facilities in the Jeanne Mance wing for psychiatric patients.

Discussions have also been held about the creation of a secure assessment room in the Emergency department where difficult and aggressive patients can be isolated, to protect both themselves and others. Acute-care services will be consolidated at HDH, and a crisis team developed. An adolescent service, in consultation with Beechgrove Children's Centre, is also planned.

RADIOLOGY

On Friday November 8, 1895, a new and unknown ray was discovered by Wilhelm Conrad Roentgen, a physics professor at the University of Wartzburg. This unknown ray, the x-ray, has had a profound influence on the treatment of human diseases and injuries. By the early 1900s anaesthesia and x-rays allowed surgeons to use metal pins in leg bones for traction. Tissues could be opened for the insertion of ivory pegs, kangaroo tendon, silver wire or wood screws. The procedures worked well. Records show that one child received four wood screws and a steel plate to help the healing of a fracture. It was not until 40 years later that the metal had to be removed because of rusting and tissue reaction in the adult man. Today's techniques use good quality x-rays, safe anaesthesia, blood transfusion and sterile conditions, and stainless steel or cobalt chromium alloy appliances which are compatible with body tissues.

The increasing demand for the information provided by x-rays triggered the opening of an x-ray department, laboratories and outpatient facilities in the new Brock wing in 1909 under Dr. Joseph P. Quigley and Sister St. Charles O'Connor. By 1918, Dr. Quigley, who served HDH until 1946, became radiologist for KGH and the military hospital as well. The x-ray department moved into the new St. Joseph's wing when it opened in 1931. One room contained an upright vertical fluoroscope, and another a stationary horizontal table. By 1945 the department had become responsible for EKG and physiotherapy as well as x-rays. It even provided some superficial x-ray treatment for skin conditions.

Dr. Ronald Burr joined HDH staff on January 1, 1946 as the Hospital's radiologist, with Sister Elizabeth MacPherson as his assistant. On March 2, 1946 the x-ray department received

new equipment, including complete x-ray units with anode tube, tilt-table, fluoroscope screen and spot-film device. A second room was equipped for superficial therapy and for special sinus and skull x-rays. Dr. Burr donated one of the tubes.

Dr. Burr remembers one patient that was both unusual and memorable, but may not be represented in the records. "This gentleman said he had a racehorse with a sore leg, and asked if we could x-ray it. I said, why I think we could. So we brought the horse up to the Brock Street entrance and backed it up to the door and brought out our small x-ray equipment that was portable. So we x-rayed the horse's leg."

Over the years the Department expanded, under Dr. Bruce Colwell, assisted by Dr. Wm. Van Alstyne. In 1957 new equipment and a new darkroom were installed, and a complete renovation in 1965 expanded facilities into seven diagnostic radiology rooms in the main department as well as a urology room in the operating room. There were now 16 registered technicians. Dr. Burr, later head of the Cancer Clinic at KGH, was succeeded by Dr. J. Stewart Lott in 1971.

In 1983-84 the department received an influx of new equipment, yet still more was needed as techniques changed and equipment improved. In 1987, the Ministry of Health approved the purchase of a CAT scanner, and a special campaign raised the funds. The installation of the CAT scanner in 1989 marked the pinnacle of the changes in the department since the first x-ray was taken in 1909 at HDH by Dr. Quigley and Sister O'Connor.

REHABILITATION MEDICINE

Currently, the department of Rehabilitation Medicine offers programs at HDH for patients with chronic pain, supported by a full rehabilitation team including a physiotherapist, occupational therapist, social worker, psychologist and vocational counsellor. Community service providers are invited to join the team as the need arises. However, the rationalization of health care in Kingston is still in progress, and rehabilitation services for patients will soon be centralized at the St. Mary's of the Lake Regional Rehabilitation Centre. All occupational therapy services will be provided at the new Centre, except for services with close linkages to clinics at the acute care hospitals. Outpatient physiotherapy services also will be delivered at the Centre, again with

the exception of services with strong linkages to such clinics as the hand clinic or paediatric orthopaedic clinic.

To meet acute therapy needs, models for the delivery of physiotherapy and occupational therapy are being designed to allow the purchase of services from St. Mary's for acute inpatients and clinics at HDH and KGH. The final consolidation, although expected to be completed by September 1994, is still in progress.

SISTER LIAISON

With HDH's need to retain its religious identity as a Catholic hospital as well as its ecumenical identity as a teaching hospital, while the numbers of Sisters working in the Hospital declined, in April 1989 the special position of Sister Liaison was established, filled by Sister Elizabeth MacPherson.

"It has been established by our Health System to keep the Health System informed and because there are so few Sisters to work in the Hospital," said Sister MacPherson. "Our lay people need some direction and help, and so I liaise between the Board and the committees and staff and so on for the Congregation, for the Sisters. In each of our hospitals now there is a Sister Liaison who keeps our Health System informed." Sister MacPherson has an office in the Hospital in which she spends several hours a day.

SOCIAL WORK

On October 7, 1988, the Social Work department, started by Sister Margaret McNeil, a 1955 graduate of St. Joseph's School of Nursing, celebrated its 25th Anniversary. "Sister Molly O'Neil, who was I believe the supervisor of Emergency there at the time, called me in Toronto and said, 'Margaret, I think somebody needs to come down here and start a social work department, and I'd like you to come.'"

Initially, the department occupied one little cubicle in the Emergency department. "I sat on one side of the desk and my secretary sat on the other side. We even went out and made house calls, just to see where that person was living, what that person needed." She remembers one couple they used to look after. "I think they had 15 children. The man was about 13 years older than his wife, and he used to tint his hair with the yellow

colouring that you coloured the margarine with, so that he could go out and get work." At times special precautions were needed. "I always carried a cigarette in my coat pocket because the people would very often offer me a cigarette because they'd be smoking themselves. I would be afraid to smoke the cigarette because I wouldn't know whether it was 'clean' or not, so I would just slip it in my pocket and slip out my own and smoke it. That was one of the tricks of the trade." Case loads at the time were about 40 a week, she said, and "many stayed on forever."

By 1985 the Social Work department had earned its spurs and under Mr. Walter Vos moved to the basement of the Johnson wing. The department is directly involved with both inpatients and outpatients, provides a follow-up service, and assists patients in obtaining the use of community resources, at times referring a particular patient to a specific agency. It is often consulted by various agencies in the community through both formal case conferences and informal discussions.

SURGERY

When people think of a hospital, they almost automatically think of surgery. When the Sisters first arrived in Canada in 1659, surgery was still limited to draining abscesses, setting broken bones, removing haemorrhoids, urinary stones and cataracts, amputating, excising breasts, and repairing strangulated hernias. Pain and infection hindered any further development. Surgery was performed in street clothes and with unwashed bare hands and often unwashed instruments. Such surgery was often a death sentence.

In 1867, Joseph Lister introduced the principles of antisepsis to destroy microbes in the air that contaminated wounds. He also insisted on using the phenic acid solution, sprayed in the operating field, to wash both surgeon's hands and patient's skin, and for soaking the surgical instruments. Louis Pasteur reinforced the principles of cleanliness, stressing the need for washing hands and using sponges and bandages that had been air-sterilized at high temperatures. By 1895, surgeons were disinfecting hands and arms with a solution of potassium permanganate, then rinsing in sodium hydroxide. Masks and gloves of white cotton were introduced at this time.

Until 1900 at HDH the Sister Pharmacist was in charge of the operating room, and sterilized dressings with a hot iron

before each operation. Later, surgical instruments and compresses were autoclaved using steam under pressure.
Dr. John Tweddell, pathologist at HDH from 1936 to 1950, was the first person to cross-match blood at HDH in the days of donor-patient transfusion. In the late 1950s, the blood bank was re-established in conjunction with laboratory renovations. For several years, Sister Irene LaRocque supervised the operating room and also managed the blood bank. She mentored Mrs. Rose Landon who later ran KGH's operating room, and Ms. Theresa Rogers who later developed operating room management and training of personnel.

Dr. Harry Warner and Dr. Maurice James, general surgeons at HDH following the Second World War, brought new ideas to the care of surgical patients because of their military experience.

In 1956 the first elective open heart surgery performed in Kingston, two mitral commiserotomies, were done by Dr. Harold Neuman, a chest surgeon, and Dr. Dermid L.C. Bingham, Professor and Head of Surgery. They were performed simultaneously in the right and left operating rooms. Resources were so strained that instruments used for one patient were washed and autoclaved and taken across the corridor for use with the other case. Dr. R. Beverley Lynn, a cardiovascular surgeon, initiated Kingston's cardiac service in 1957.

Then came the organization of a Surgical Intensive Care Unit in 1961, with care being provided by specialized surgical nurses. Beds which could also serve as stretchers were used on the Unit, the first two donated by the Women's Auxiliary.

General surgery today includes surgery of the head and neck, the digestive tract, the chest, the breast, endocrine system, the trunk, soft tissue, and limbs and vessels, excluding the heart. It also includes the management and direction of the care of trauma. Both HDH and KGH provide general surgery services. At HDH, the concentration is on general community surgery, paediatrics general surgery, gastrointestinal surgery and plastic surgery.

The department has changed considerably over the past 25 years. The once very active obstetrics and gynaecology service has now gone to KGH, as has the urology service. The paediatrics service, for a brief period at KGH, has now returned. Plastic surgery, including microvascular head and neck reconstructive surgery and burns repair, has come to HDH, as has the

specialty of hand and microvascular surgery. Joint replacement surgery, orthopaedic arthroscopy, spinal surgery and paediatric surgery are strengths today, while general surgery has become somewhat focussed on the diseases of the gastrointestinal tract.

In 1957, one case treated by Dr. William Ghent, Chief of Surgery from 1957 to 1974, won national recognition. Police officer Cranston de St. Remi, on the evening of November 29, was shot several times, receiving one bullet in the right ventricle of the heart. He was rushed to the operating room at HDH where Dr. Ghent also called in cardiologist Dr. Milliken to monitor the ECG. There was no time for the heart-lung machine to be hooked up or for lowering body temperature using a hypothermia blanket to make the surgery safer by slowing the heart. Cutting into the chest quickly, Dr. Ghent revealed the heart and sewed up the jagged gash. One of the sutures gave way, blood gushed out, and the heart stopped. He quickly continued his stitching. One and a half minutes later the last suture was in place. He began to massage the heart manually. Two minutes 30 seconds after St. Remi's heart had stopped, it began to beat again. A drainage tube was inserted and the chest incision closed. Still too critical to be moved, St. Remi spent the night on the operating table. At dawn he woke up, and recovered successfully. One report said, "Cranston de St. Remi just refused to die."

In the 1950s, neurosurgeon Dr. James Flood operated at HDH three days a week, commuting from Watertown to perform these services. Noted was his surgery on Parkinson's disease patients to relieve their tremors.

Around 1967 two operations using for the first time a pig liver to perfuse human blood to rest the patient's liver were performed at HDH under the supervision of Dr. Ivan Beck. Physiologist Dr. Duncan Sinclair (now Vice-Principal Health Sciences and Dean of Medicine) participated at both operations. Dr. Gian Paloschi was involved as a surgeon in the first operation, and Dr. William Ghent in the second.

In the early 1980s the operating rooms were moved to the new Jeanne Mance wing, providing much more aseptic space in a much brighter, safer area.

In December 1989 HDH highlighted an innovative new surgical procedure for the treatment of throat cancer. It involved the removal and transfer of a piece of bowel to the neck. The operation had been performed only a few times previously in London and Toronto. Traditionally, with comparable throat

cancers many patients required the removal of the larynx (voice box), and sometimes part of the pharynx (swallowing throat), costing them the ability to swallow foods and liquids normally. The new treatment offered less time in surgery, potentially fewer complications, and more reliable healing.

Also being performed at HDH, by Dr. Simon Wren, is surgery for the morbidly obese, in which the stomach is turned into a small pouch to prevent overeating. About 50 patients a year from the area benefit from his work.

Hospital stays have been considerably shortened, and patients mobilized much earlier. Many conditions formerly treated by surgery can now be alleviated with medication. Other surgical procedures which once meant a five- or six-day stay in hospital, such as a hernia repair or removal of cartilage from the knee, are now outpatient ambulatory surgical treatments. About 60 percent of all surgery is now done on an outpatient basis, in part because surgery has become less invasive. Today, there are five operating rooms used on a daily basis, with the assistance of about 60 staff, and at times a sixth accommodates local anaesthetics.

The recent introduction of various lasers permits the department to offer more sophisticated services in general surgery, urology, bronchology, gastrointestinal surgery, and head and neck surgery, in addition to the ophthalmologic lasers already in use in eye surgery. Some types of laser actually vaporize tissue, and can be used for esophageal tumours as a palliative treatment to remove some tissue so that patients can swallow. Operating microscopes are now being used in surgery involving grafts and the joining of blood vessels.

A major advance in techniques which makes surgery much less invasive has been the recent introduction of laparoscopic surgery, in which a small incision only about four or five inches long is used. Fibre optics permitted the development in the late 1960s and early 1970s of arthroscopy whereby orthopaedic surgeons see inside the knee joint and later actually perform operations through the tiny opening. It further developed into the laparoscope, which allowed entrance through a small wound in the abdomen to see the abdominal structures. Then operating instruments were perfected with which the surgeon can remove a gall bladder, for example, through the extremely small incision, shortening the hospital stay to, at the

most, one day. Whenever possible, surgery is carried out on an outpatient basis.

New gadgets such as surgical glue and surgical zippers have also been introduced as part of the operating room paraphernalia.

Something old, indeed a 2,500-year-old treatment, has also been added to surgical techniques. In 1993 medicinal leeches were re-employed for the first time since 1845 at HDH.

In the first modern instance, a young girl had lacerations on one side of her face, and her cheek was partially removed. Plastic surgeon Dr. John Davidson discovered there was no venous outflow from the cheek after surgery, and was afraid the cheek could be lost. After some quick phone calls, Toronto General Hospital's plastic surgery unit rushed some leeches to Kingston. After five days of "leeching", her tissues were much improved. The leeches had helped remove old blood from the cheek tissue so that freshly-oxygenated blood could enter and keep it alive until the lacerations healed. Another young patient received successful leech treatment on his leg. A third patient, who had a finger reattached after a wood-splitter accident, also received leech treatment. Since for best results leeches need to be applied within six to eight hours of surgery, the pharmacy now maintains a stock of about 80 medicinal leeches.

On February 8, 1994, the Operating Room Suite and the new Surgical Step-Down Unit on Johnson 7 were dedicated to the memory of Dr. William R. Ghent, HDH's Surgeon-in-Chief for 17 years and Deputy Surgeon-in-Chief for a further 13 years. The surgical step-down unit is intended to meet the needs of patients progressing from a critical phase to a more stable phase requiring a declining amount of nursing supervision and intervention. The three-bed unit has been established in room 773 on Johnson 7. It will receive patients from Emergency, Surgical Intensive Care Unit, Recovery Room and the surgical units.

The General Surgery service is also a teaching service. It offers a two-year core of basic science training and three subsequent years in general surgery training. As well, the program contains an elective post-certificate year in community surgery to provide students with basic knowledge for eventual practice in smaller communities.

The advent of antibiotics and intensive care systems and their technology now allows the surgeons to prevent death by being more active in treating disease. This has now created a

new ethical problem, says Dr. Don Taylor, Deputy Chief of Surgery. "Keeping people alive when it is inappropriate is a possibility, but is perhaps ethically inappropriate. Some of the dilemmas of whom to treat and how actively do we treat them are conditions that have been created by our technology and our science which really didn't exist 25 years ago."

THE TRADES

The history of a hospital is not only the history of construction and caregivers. Many others are responsible for the quality of care. A huge range of tradespeople - cooks, bakers, dishwashers, carpenters, electricians, plumbers, painters, laundry workers, seamstresses, housekeepers, garbagemen, truck drivers and stationary engineers, among many others, are all needed.

The magnitude of the services rendered is staggering. For example, during the fiscal 1993/94 year, 10,252,000 kilowatt hours of electricity were used, 62,415,000 pounds of steam employed in heating, sterilizing, etc., and 1,800 fluorescent light tubes changed. Hospital walls received 260 gallons of paint, and 5,250 packages of paper towels, 4,800 rolls of toilet paper, and 12,000 containers of liquid hand soap were used. In all, there are 450,000 gross square feet of floor area and 2,350 door openings throughout the Hospital.

The Switchboard

A web of communications links departments within the Hospital to the outside world, and at the hub of this web is the switchboard which has grown more complex over the years.

According to supervisor Patty Anson, 25 years ago a busy hour on duty at the switchboard would mean responding to 15 or 20 calls on the 10 incoming lines. The board itself at that time used cords for its operation. Two operators worked the day shift, one the evening, and a special half shift from 5 to 8 p.m. covered incoming calls during the supper hours. One duty of the operator coming on duty early in the morning was to call the security guard at about 6 a.m. before the nurses got off work at 7. "At that time where the Jeanne Mance wing is now was the Emergency area and the staff could park there at night. The security guard would warm up all the cars in the cold winter

while he did the parking lot duty to make sure the girls got in and out of the building safe and sound."

Overhead paging was done with a manual public address system. Today, the paging system shuts off automatically, 37 incoming lines to the switchboard no longer use cords, an "auto-attendant" line provides for direct dialling when the extension is known, and switchboard operators handle 150 to 165 calls per hour. The new switchboard was installed about 15 years ago. Yet there are still only three operators working the daytime shift.

Instead of overhead paging, "We put people on pagers. I keep saying we talk to their heart pocket or their belt loop. When I was here 25 years ago we knew every doctor by his face and by his voice. Now we know very few of the clerks and the interns because of the fact that we don't get to meet them other than the day they pick up the pager and the day they return it," Patty says. And laughs, "We even have a special prayer we say when doctors lose their pagers — and it works."

One very recent change is the standardization of various voice codes throughout the hospital systems in Ontario. Instead of each hospital having different codes, for example "code zero" at one or "Dr. Smith" at another for cardiac arrest, the new codes are colour codes.

Maintenance

The maintenance department is responsible for the largest part of the investment in the Hospital, the buildings and equipment, with costs that escalate as buildings age. A number of trades are involved: carpenters, electricians, plumbers, painters. Requests for maintenance never end, said Gerard Boudreau, employed at HDH from 1950 to 1985 and a member of the 25-Year Club, for everything from burned-out ceiling lights to a blocked toilet or a leak in a ceiling.

It was not always easy to find the source of the problem, especially in the older buildings. For example, it took three years to find what caused the leak in the roof at the back of the Chapel, Boudreau said. "We finally found out there was no insulation in the ceiling in the Chapel. The air was coming up in the Chapel attic and freezing on the ceiling. Every time the sun came out it would melt; but when we got the call that it was leaking there was no ice. We put insulation in the ceiling, and that stopped it completely."

Sometimes designs cause problems. At one point the garbage disposal in the kitchen was always getting plugged. The chief engineer checked the blueprints and found that the right size of pipe had been installed. However, said Boudreau, "I said I didn't care if it was the right size of pipe or not. I increased it to four inches, and we never had any trouble after that."

But not all maintenance moments are solemn. Boudreau worked in the paint shop for his first two years at HDH, and remembers when he and his partner were painting in the operating room one night. "They always paint operating rooms green, a kind of dark light green. My partner was up on the ladder with a gallon of paint. I don't know if the leg of the ladder broke or what, but when he started falling down he grabbed whatever was on top of a long cupboard. It happened to be a box of cotton balls. It was just like snow in there, all over the place."

Material Management Service

One component of the Material Management Service at HDH, once known as The Stores and operated by Mike Cybulski, is the linen service. At one time all laundry was done within the Hospital itself. Today, HDH is a partner in the Kingston Regional Hospital Laundry.

"Last year HDH used 1,236,000 pounds of linen, which works out to about 17.6 pounds per patient day," said George Spence, Supervisor, Materiel Distribution. "The nursing units all have established quotas based on the number of beds they have or the procedures they do." Dirty linen is picked up and sent to the regional facility, and clean linen delivered in turn to the nursing units.

The Service also has a uniform shop. "The Hospital supplies uniforms to most of its employees, and the girl in the shop issues it and will do adjustments on it. She is also responsible for washing numerous items including uniforms, a lot of the lab coats, the curtains and drapes and the bedside cubicle curtains." Patients can also access the service.

The Material Management Service also includes the stores department, which handles "anything that comes into the Hospital that is used as an inventory product. That includes the bandaids, the IV solutions, all those kinds of things," said Spence. The Hospital keeps an inventory of about $300,000 worth of supplies, "and probably another $300,000 on the floors in the nursing unit. For example, we used over 800,000

incontinent pads last year. This is a hospital and we're talking medical-surgical supplies, not something that you can run down to your local hardware store and get," says Spence.

Products enter HDH through Shipping and Receiving. "We have three very active delivery bays, and often there's trucks waiting to back in. It's a constant process of things coming in and things going out. The computer system maintains a constant or perpetual on-hand balance in the stores so that we can go in at virtually any time and see what we have in stock of what product."

Stores must then be distributed, and the portering service delivers materials and patients throughout the Hospital. "Last year, for example, the portering department did over 80,000 calls, which included everything from admitting people who come in through Emerg and delivering them up to the floors, delivering people from the floors to the OR, taking them from the OR back to the rooms, and delivering all the paraphernalia involved with running a hospital which includes things like the medical charts, x-ray films, requisitions for various tests, all kinds of things."

Hospitals, like other organizations, operate on a sea of paper, and the print shop, manned by one full-time person, produces forms, reports, and booklets. "We provide photocopying service for a number of areas and functions, things like board and committee minutes. The print shop will photocopy, collate, staple, help in the booklet design, and deliver the end product. We do 140,000 to 150,000 copies per month on one of the machines, the Xerox 9500. We also have 21 other photocopiers throughout the Hospital that we are responsible for."

Leaving the Hospital are huge quantities of waste, some of it biohazardous. A company is contracted to remove and treat all biohazardous material in accordance with safety regulations. Radioactive waste is also removed, using special precautions. Another contractor provides a shredding service for confidential material once a week at the Hospital. "The biggest components of waste that we generate are tin cans, bottles and empty pop cans, and they're all separated for recycling," says Spence. "We have a very effective paper recycling program. We also have a tremendous amount of cardboard, with all the boxes and containers and stuff that come into the Hospital, so we have literally truck loads and truckloads of it that is separated and shipped back to be reprocessed as well. Kitchen waste is separated and handle

by a separate contractor, and then there's the general green garbage bag waste that's left over, and we have a company that comes and picks that up as well."

For well over a century, housekeeping was the responsibility of anyone who wasn't busy doing something else, including the Sisters. Now, cleaning with its new materials and equipment is much more sophisticated. The housekeeping department plays an important role in the prevention of infections as it keeps the rooms, corridors and offices spotless. Housekeeping duties too have changed at HDH. Thirty-odd years ago, the first thing a member of the housekeeping staff did was to make bacon, toast and eggs for the patients' breakfasts, set up the trays, and carry them to the patients. Later, the housekeepers would pick up the trays, strip and wash the dishes, and then start in with the daily work of scrubbing, waxing and polishing the stairs. They also made the beds when patients were transferred to another floor or discharged, and dusted the furniture.

According to Audry Pinch and Marg Van Hooser of Housekeeping, who both have served at the Hospital for over 30 years, stairs were done on hands and knees with little brushes. Both remember vividly their first encounters with electric floor polishers. Audry was instructed to polish the furniture and floor in a board room, and told there's nothing to handling a floor polisher. "It was bouncing all over, hit every chair, and finally whined into the fireplace." And in Marg's first encounter with a polisher, it almost pulled her down the stairs.

Cleaning techniques have also changed. At one time special isolation rooms were used for some patients, housekeepers were required to wear gowns and change mops from room to room, and wash down the walls after the patient left. Today, unless an extremely dangerous disease is involved, only standard cleaning is performed. But nowadays, all body fluids are considered hazardous, and everyone in danger of contact with any body fluids is required to wear gloves. The Hospital has initiated the technique known as "universal precautions".

By 1991, in keeping with the societal trend toward the elimination of smoking, such was excluded in all offices. Visitors had been prohibited from smoking for a couple of years. The Hospital decided not to establish any new smoking areas, although it recognizes the individual's need to smoke in some cases and reviews each exceptional case to ensure staff and other patients are not compromised by second-hand smoke.

A staff committee was formed in the early 1990s to develop a program to provide integrated health care programs or services that will be culturally and racially sensitive, and responsible and accessible to all members of the community. Kingston attracts many immigrants and refugees, but numbers of individual groups are so small the Hospital often has difficulty in identifying them. It is trying to develop ways to understand the cultural and linguistic backgrounds of patients and respond appropriately to their needs. Plans include providing employee education programs, interpretive services, developing patient educational and communication tools, and finding ways to ensure adequate follow-up after discharge. Many of these patients do not understand how to gain access to health services, for example.

A shift towards effective but costly technology and concentration on large institutions has resulted from public health concerns. In every department, the language of bureaucracy and statistics has replaced the anecdotes and much of the community spirit of the early days.

For the last 20 years, health care has shifted to a large extent from the hospital into the community. Emphasis on proper nutrition and prevention of illness shifted the focus outwards beyond hospital walls.

Medical advances, together with budget cuts, have meant that now patients are spending more time at home and less in hospital. There are fewer inpatients; their needs are being met as outpatients or by day surgery. Even those admitted are staying for shorter periods of time, and are often leaving still with medical needs. At HDH, the number of beds has dropped from 256 to 201 since 1990, and the average days of hospital stay from 6.4 to 6.1. The strain on health care resources is shifting to home care services.

More emphasis is being placed on lower cost alternatives such as home care and chronic home care programs, chronic care facilities and nursing homes for the chronically ill, the convalescent and the disabled. Today, the trend is even more towards maintaining the elderly in their homes as long as possible by providing needed assistance. Now, the major problems in health care are not epidemic diseases but rather the choices to be made in health care and the care of an aging population.

And always, patient care at HDH focuses on the human dimension rather than the technological magic. The distinction,

according to Sister Elizabeth MacPherson, is clear. "We felt that the more advanced techniques are 'high tech' and we are 'high touch'. High tech is great, but you can lose the caring aspect with the person because you are so busy with the technology."

The Pursuit of Knowledge

Professorial activities at any university include three major components — teaching, administration and research. When medical doctors participate in university-centred activities, a fourth obligation is added, that of clinical activities.

When HDH became an integral part of the teaching program at Queen's University Medical School, it also needed to add research and teaching to its clinical and administrative responsibilities. Research activities at HDH, even in their infancy, have been outstanding, with some of its research discoveries achieving world-class level; yet few are aware of the search for knowledge taking place at the Hospital.

Some of the research is basic "laboratory bench", some is based on clinical studies, and some investigators are looking at the more generalized problems associated with the provision of health care to all segments of society.

Probably the earliest to engage in "bench" research was Dr. Douglas Waugh, a diagnostic pathologist and Director of Labs at HDH from the late 1950s to 1964, who was also Dean of Medicine in the early 1970s. Dr. Waugh had done research at McGill University before he came to HDH; and although he spent most of his time as Director of Labs he maintained his research program and in fact encouraged residents to participate. He was able to acquire the first electron microscope at HDH for his research, at a time when electron microscopy was on the cutting edge of research technique. The electron microscope can reveal cellular structure that is too small to be identified under the standard light microscope, and he used his equipment to study abnormal structures in liver cells. He was particularly interested in the possible relationship between altered function in illness and disease to alterations in the cellular structure at the ultramicroscopic level.

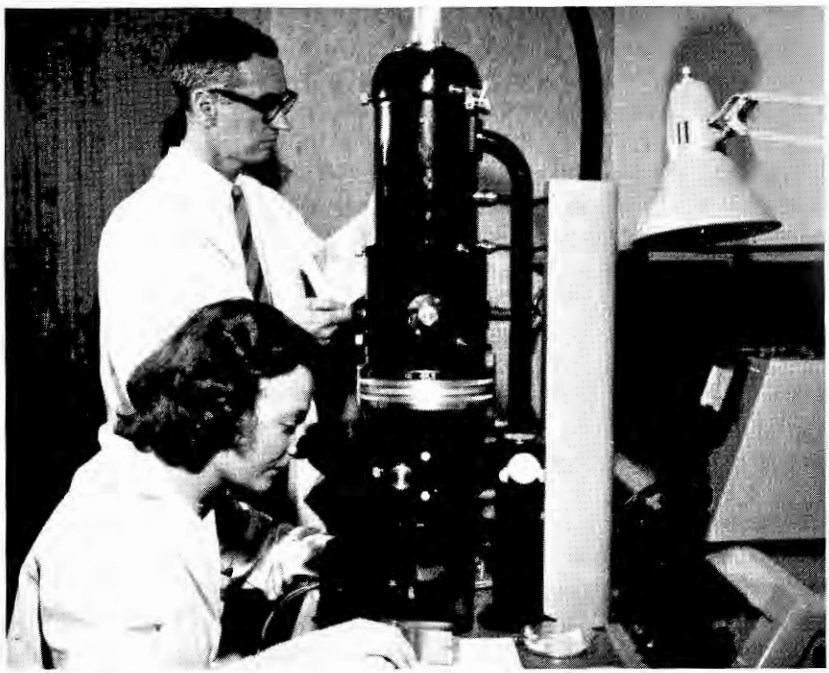


Photo by Wallace Berry

Dr. Douglas Waugh with Dr. Ellen Van der Hoeven, Pathologist, 1960.

A greater emphasis was placed on formalized research at HDH in the late 1960s and early 1970s; and in 1969 a grant of $560,000 was received from the Ontario Lottery Research Fund for the building of 17 new research laboratories at the Hospital: eight on St. Joseph's (now Brock's) fourth floor, eight on Johnson 0, and one on the ground floor of the Murray building. The renovation work was completed by March 31, 1979, and the investigations that took place in those laboratories expanded our fund of knowledge tremendously.

During the late 1970s and early 1980s Dr. Adolfo de Bold operated a research laboratory adjacent to the gastrointestinal research labs, sponsored to some degree by the Sisters and the university. Although many people considered that he was operating in a vacuum and held very little hope for the results of his research, he confounded his doubters. His research resulted in a discovery ranked as a world-class breakthrough in the

understanding of major heart problems. He uncovered cardionatrin, an atrionaturietic factor which regulates fluid retention in the body and is found in the atrium of the heart. It is part of the body's regulatory mechanism of sodium and water.

Currently, the largest area of research activity in the Hospital is the gastrointestinal division, involved in both basic and clinical research since 1966, expanded with the establishment in 1982 of the Gastrointestinal Diseases Research Unit with Dr. Ivan Beck as Director. At present the Unit is under the directorship of Dr. William Paterson and includes the clinicians of the department, as well as Dr. Paritosh K. Dinda, a pure research scientist who came to Kingston with Dr. Beck, and basic researchers Drs. Mikael Buell and Ceredwyn Hill.

The Unit offers both undergraduate and post-graduate research training, as well as research fellowships. Kingston is unique in that there are no gastroenterologists in private practice. All patients are seen by a full-time Queen's faculty member who is also a member of the Research Unit. The patient base for clinical research is thus far greater than one would expect for a centre the size of Queen's. The Unit is currently looking at new pharmacological approaches to the treatment of gastrointestinal disease. Individual members of the Unit have such widely varied research interests as the mechanisms of mucosal injury throughout the gut, targeted drug delivery, the causes of inflammatory bowel disease, mechanisms that regulate local blood flow in the alimentary tract, immune reactions, and the control of esophageal motor function. A major strength of the unit is its interdisciplinary membership - clinicians, basic scientists and students from Medicine, Biology, Surgery, Physiology, and Microbiology and Immunology - in a collaboration that is rapidly expanding knowledge of the gastrointestinal tract, its diseases, and their treatment. Late in December 1994 the department received an $850,000 three-year grant to establish an education centre in Kingston to educate physicians on motility disorders.

Psychiatry is another major research-oriented department. One study is attempting to find the relationship between abuse in marital relationships and self-disclosure, possibly an avenue for prevention and even treatment of abuse. Eating disorders in children are being investigated, especially the family factors that may influence course and outcome. Studies now being done on forensic sexual problems or dysfunctions could help in the eventual treatment of dangerous sexual offenders.

Finally, the department is looking at "first lifetime episode" schizophrenia and its course and outcome. Schizophrenia is a common condition, affecting 1 in 100 Canadians. It usually starts in late adolescence or early adulthood with symptoms like delusions and hallucinations. In the past health professionals, for a variety of reasons, have been slow to make the diagnosis, in part because they had doubts that it could be diagnosed accurately and in part because of the impact on family emotions. There was an unsubstantiated theory in the past that somebody given a diagnostic "label" would then live out that life. Most of the research has therefore been done on people with a chronic and relapsing course. The work currently in progress attempts to identify the beginning of the disorder, to see if some of the findings that may have been artifacts of treatment or medication are present at the beginning, and if there may be better ways of preventing some of the disorder's disability.

The department of Otolaryngology has a wide range of research projects currently under way, and others involving respirology and allergy planned for the future. One such project, in conjunction with the Cancer Clinic, has developed a database containing complete and accurate data on every patient with cancer of the head and neck since January 1, 1985. By September 1994 data on 580 patients were in the database. The vast majority of patients in that group are treated in a combined clinic at KGH and the Cancer Clinic, with surgery being performed mainly at HDH. The database is considered to be possibly the largest and most accurate in the world.

During the Regional Communications Unit's existence, much research involved speech development in developmentally delayed patients. Some research in that area is still being undertaken. Peripheral to HDH but within the department, a speech pathologist is currently working in the community doing research in language development in the developmentally impaired. Other ongoing research, in cooperation with the department of psychology, involves the investigation of specific voice disorders.

Current projects include analysis of the benefits of ventilating tubes; analysis of the use of computer models to treat voice disorders, in conjunction with the departments of Speech Pathology and Psychology; and review of nystagmus (continuous rolling movement of the eyeball) as the result of vestibular nerve

disease. One of the problems with new ear, nose and throat research, as in so many other areas of investigation, is the cost of the new specialized research "toys", priced so high as to be out of reach of most Canadian researchers.

Research in orthopaedics is also important at the Hospital, ranging from involvement in the Clinical Mechanics Unit related to joint replacements, to outcome and economic studies in association with the department of Community Health and Epidemiology. For example Dr. John Hazlett, one of the first researchers in orthopaedics at the Hospital, became interested in the cause of back pain. He looked at interspinous process bursitis as one possible cause, using autopsy material from both HDH and KGH. In broader research, over the last 10 years Dr. Anthony Ashworth has been investigating socio-economic issues and in particular the efficiency and effectiveness of care and its costs.

The Paediatric department has a number of major research interests, including genetics, but the research is conducted in Richardson Laboratories associated with Queen's.

There is limited "bench" research but a lot of clinical interest at HDH. One project includes assessment of protocols for the treatment of cancer (all children with cancer are admitted to HDH), and other clinical research studies on child abuse and child neglect. Some studies have been done by the Child Development Centre on chronic disease in childhood. Parents' reception of asthma treatment for hospitalized children has been investigated, and one research project now being developed studies the effectiveness of secondary and tertiary levels of care in mid-sized communities.

It may seem as if the Emergency department is the last department in any hospital that would be active in research, but in fact the department is actively involved in the investigation of injury prevention, from farm accidents and childhood accidents to motor vehicle accidents. Admissions provide a current picture of the most acute disease or injury problems, and identify the target groups for preventative strategies. The Emergency department has also been heavily committed to structuring the research component of the expansion of the paramedic program across the area.

Research is costly and space-consuming, it is difficult and time-consuming to obtain funding, and clinicians are committed not by choice but by demand to deliver clinical service, to

teach at the undergraduate and postgraduate level, and to be involved in administrative activity. Nonetheless some of the emphasis in the department of Surgery is shifting towards a research component. Dr. Simon Wren is one of the few "bench" researchers in the department, with interests in nutrition and in the behaviour of white blood cells. Aortic aneurysms are being investigated, as is surgical treatment of non-fracture spine injuries in motor vehicle accidents.

Laser surgery is now attracting a great deal of attention. A laser emits a concentrated beam of light that travels only in one direction and is much more intense than ordinary light. Each type of laser emits a light of a single wavelength, and with different types made from different materials, some are better suited for cutting, evaporating, or coagulating tissue.

The CO_2 laser is used most often for ear, nose and throat surgery. Its energy, when absorbed, produces steam which ruptures cells and destroys tissue. This lets the surgeon remove malignant and benign tumours more easily with less blood loss and less localized swelling. Wounds heal quickly, since the light beam is so precise that very little normal tissue is injured. These lasers are also used in oral and nasal cavities and on skin and breasts.

The ophthalmic YAG laser, one of very few in Canada, explodes tissue and can destroy both minute and large areas. It can cut eye tissue, and is useful in cataract surgery. A similar laser can destroy large tumours in the esophagus, stomach or large intestine. It cauterizes as it vaporizes tissue, reducing blood loss. The patient can be treated on a short-stay or outpatient basis and resume relatively normal living much sooner.

The laser welding of tissues is one area being investigated at HDH. The intense laser-produced heat produces a sticky coagulant from the dissolved tissue protein, a coagulant which can serve as a glue to hold severed tissue together until healing forms a more permanent bond. The direction of the laser beam can be altered by prisms in an endoscope, and it may also be possible to combine ultrasound with laser technology, a promising new area of research.

Research in the department of Family Medicine takes a more generalized form than "bench" or clinically-based research. Some studies have looked at the best ways of ensuring access to the medical system for preventive tests such as Pap smears,

blood pressure checks and breast examinations. For example, in Ontario at the moment half the women who have invasive cancer of the cervix have never had a Pap test. What is now needed is not more research on how to cure cancer of the cervix, but on persuading women to have their Pap smears.

Other questions in the provision of health care also need answers. How do you persuade people to stop smoking? How do you get them to take their medication? The research is not "high tech" science; it is science translated to the level of people and families and communities.

A number of research projects have been in the areas of women's health - wife abuse, physicians' attitudes to it, and progress in medical education in shaping these attitudes; what can be done about violence against women in pregnancy. Why are women in Canada less likely than men to obtain haemodialysis when their kidneys fail? Why are women more likely to die with their first heart attack than men, and much less likely to have cardiac catheterization? Even clinical tests do not take into account the difference between men and women. Historically women have been protected against drug trials because of the possible effect on fetuses or lactation; but now the young healthy 22-year-old male is the norm. The elderly and women form groups in which much less is known about the effect of medications. Nurses are also researchers. In the early 1990s nurses began to look at two areas of health care for the elderly: first, a review of ways of enhancing the care of the aged, since a geriatric patient often requires a different approach; and a review of the phenomenon of elder abuse. The nursing division is also involved with a very sophisticated research study on the effects of repeated hospitalization on children who have repeated surgery; and has performed some very good clinical studies on the effects of chronic inflammatory disease of the bowel.

Space constraints make it impossible to list all the departments at the Hospital involved in research, and all the research interests. However, a few other examples of research at HDH include investigation of the effects of various anaesthetic agents on elderly patients, who can be a challenge from both the technical and pharmacological viewpoints, in a program begun in the early 1980s by the department of Anaesthesia. Clinical residents in the department of Ophthalmology undertake patient-focused studies on the problems experienced; and the department has recently received $20,000 to study the use of

interferon for age-related ocular degeneration. The department of Pathology is actively engaged in a study of corneal lesions by light and scanning electronic microscopy, in cooperation with Ophthalmology. Together with Pharmacy, it is looking at the hepatotoxic action of drugs. Research will expand at HDH. Dr. Henry Dinsdale, formerly the Chief of Medicine at HDH for a number of years, has recently been appointed as Vice-Dean of Medical Research at the Faculty of Medicine at Queen's and as Director of Research at KGH and HDH, with a responsibility to facilitate, promote and encourage research in both hospitals.

Quite apart from research in individual diseases and individual behavioural questions, the future holds a tremendous opportunity for research into better interactions with the society that depends on the medical community for the provision of health care and health services of all kinds, and into the most appropriate relationship between patient need and those services, says Vice-Principal Health Sciences Dr. Duncan Sinclair. Operating efficiencies, rationalization of services, and the alternative funding plan for physicians which eliminates fee-for-service, all provide tremendous health services research opportunities.

We also need to find out how to use physicians effectively so that they are challenged maximally all of the time, doing tertiary care work as opposed to work that could be done by other health care professionals; yet we must assure the highest quality of service and quality control. The future holds a tremendous potential for HDH in particular for health services research.

As a Catholic hospital, HDH demonstrates a value system which reflects Catholic mores — compassionate caring for the sick, belief in life after death, and belief that enduring personal pain through the grace of God can lead to personal growth. These views are shared by many of other faiths.

On May 12, 1865, exactly 200 years after Pope Alexander VII had confirmed and approved the Order, Pius IX approved and confirmed its rules and constitution, a memorable event in the history of the Religious Hospitallers of St. Joseph.

The Order was semi-cloistered, keeping the rule of St. Augustine and especially the rule of Silence. The Sisters were cloistered except for their work on the Hospital floor. Visitors stayed on the outside of a grille, and the part of the choir used by the Sisters was closed from the view of others. In the 1901 translation of the French edition of 1850 of "The Customary and Little Rules of the Religious Hospitallers of the Congregation of St. Joseph," the regulations governing their daily life and housing needs were laid out in minute detail. Stress was laid on the careful husbandry of all their resources, and on being "guided by the rules of holy poverty." The rules of cloister had to be strictly obeyed. Sisters could not travel unaccompanied; and if the Sister Pharmacist needed an apothecary's assistance, she always had to be accompanied by another Sister when in his presence.

In view of the care provided by the Sisters to all who need help, it is interesting to note an earlier rule, that "The Hôtel-Dieu will not receive any patient affected with contagious or incurable disease, any pregnant woman, or any children under seven years of age; but if younger children be admitted they must be such as are not troublesome..." In their first year in Kingston, that rule had already been shattered as they cared for typhus victims and then accepted the orphans of the epidemic.

The first stage of religious training as a postulant lasted from six months to a year. Postulants wore a black dress, white collar, and little bonnet and veil, and entered into the religious life of the community. When the Order was founded in France, to be termed a "religious order" they had to encompass the entire monastic tradition of veils, cloister, enclosure, prayer life, and so on; something of an anomaly because they were also active Sisters working in the Hospital.

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

Sister Florence Campion, RHSJ, 1898.

The Sisters rose at 5 a.m., went to Chapel for community Mass and meditation, and then had breakfast. Novices were assigned different duties in the Hospital, but returned to the monastery at 11 a.m. for spiritual reading, and ate their noon meal in the dining room, monastically called the Refectory, at long tables. They ate in silence, after saying Grace in Latin. The Superior gave a clap to begin the meal and a clap to end it. One Sister was assigned to read each day throughout the duration of the meal. Novices went back to work in the afternoon, returned to recite the Liturgical Hour of Vespers at 4 p.m., ate their

evening meal, enjoyed an hour of recreation in common following the meal, then had night prayers and went to bed at 9 p.m. in Grand Silence, silence except for extreme emergencies until the following morning.

If it were necessary for the Sisters to attend meetings, they would be taken to the meeting. It was not permissible even to go out onto the sidewalk and walk around.

Their lives were confined by the religious life in the Monastery, and the work life in the Hospital or School of Nursing. Days off did not exist, although they did have an eight-day annual Retreat given in the Chapel or Monastery. If a family member was seriously ill, they were permitted to go home. Visitors were permitted only in the special parlour, but were not allowed to eat with the Sisters. There was a special visitors' dining room with one Sister assigned to serve them.

Following the postulate, a canonical year was spent completely in the monastery, with no Hospital assignments. It was a serious year of spiritual formation. At the end of that year, novices took temporary vows for three years and were assigned to various duties, and then made their final vows.

Although in 1925 the cloister grille, a symbol of Papal enclosure, was removed and Sisters were allowed the freedom to attend necessary professional meetings outside the Hospital with lay nurses, in the 1940s the Sisters still lived a semi-cloistered life. To visit, said one student nurse of the time, the visitor rang the front bell for admission. If a Sister were having a cup of tea in the kitchen privacy was required, nor could a Sister be invited out for dinner at a restaurant.

For the handful of non-Catholic students entering the St. Joseph School of Nursing, the Sisters were somewhat legendary. Audrey Mantle entered the School in 1939. "I had never talked to a nun until the night I entered training. I thought they had no feet — they just glided along," she laughed. In 1945, she herself entered the Order and assumed the same garb.

When Hotel Dieu Kingston was first founded, the Sisters used part of the main Hospital building as a monastery; but increasing admissions of the sick made separate quarters necessary. On June 13, 1897 Archbishop Cleary laid the cornerstone of a new monastery on Johnson Street, torn down in 1964 for the Johnson Street wing.

Sisters were delighted when on August 11, 1930 the R100, "Queen of the Air", carrying 47 passengers on a publicity

flight in eastern North America, including visits to Ottawa, Toronto, Peterborough and Niagara Falls, flew over on its way back to Montreal. It passed low over the garden enclosure about 12:30, the recreation hour. The dirigible just skirted the top of the tall border trees. The Annals of the Sisters record their reaction: "How good God is to His spoiled children. Divine Providence directed its route to recreate His children of the enclosure." They also listened with great interest to the first Papal broadcast to the world on February 12, 1931 when Pius XI, speaking in Latin from Rome during the ninth year of his reign, concluded with the Papal benediction. Speaking on a radio sent to His Holiness by Marconi, his words were translated from Latin into several of the major languages.

On May 16-18, 1936, the Order held its Tercentenary celebrations marking 300 years of service since its foundation at La Flèche. In October 1950, the community room and the monastery entrance were renovated: painted, new linoleum laid, and new drapes installed on the windows. In May 1951 landscaping of the convent gardens included lawns, gravel paths, small trees, and a summerhouse, "Nazareth."

On July 28, 1960, the feast of the Co-Foundress Marie de la Ferre, the Kingston Sisters moved into a "new" convent, the former residence for the student nurses constructed in 1923 and vacated when the nurses moved into the Jeanne Mance Residence. This is now the Mary Alice wing of the Hospital. The 33-bed home had running water in each room, an elevator, a cafeteria, a library, a parlour, and lavatory facilities.

In November 1962 came a symbolic blow, when the traditional fence surrounding the convent property on Johnson Street was toppled.

Space constraints caused the area available for the Sisters' use to shrink. On February 19, 1974 Sister Elizabeth Rouble announced that it would be necessary for Sisters to share the ground floor of their residence with the Emergency Department, effective about April 1. The second floor of the residence was to become a dining area as well as the community room area. There were still 20 bedrooms in the convent, with only 12 Sisters. The second floor would be renovated as a kitchenette and dining area.

The Sisters then agreed to give up the ground floor completely, and in April 1975 work began on more renovations of the second floor of the convent. The estimated cost to turn the

dining room, laundry room, kitchenette, community room, reception area and Superior's office into extended clinic areas amounted to $300,000. By September 23 cupboards were being transferred from the first to the second floors. The sewing room on the second floor became the reception area for guests. Three bedrooms became the kitchenette and the dining area, and the Ladies Auxiliary donated $1,300 towards an electrically heated food cart. The former library came into service as the community room. By October 17, the Sisters moved into the newly renovated convent area and ate in the cafeteria, a new experience. On October 31, new carpeting was installed in the convent area.

Five years later, on February 22, 1980, the Sisters moved from the 1923 nurses' residence where they had lived for 20 years to 225 Johnson, former home of eye specialist Dr. C.E. O'Connor, purchased in 1976. This was their fifth move in their 134 years of Kingston residence.

Photo by Sister Mary Monica Hammond, RHSJ

RHSJ Sisters in Residence, 1995.

L-R Seated: Evelyn Leonard, Mary Coderre
Standing: Rosemarie Kugel, Marilyn Larocque, Elizabeth MacPherson, Jane Wahleithner

They are still missed at the Hospital. "We live waiting for the day that they move back in, because they did bring peace to this building; and they still do," said Patty Anson, switchboard supervisor. "You always knew they were there, and they were always there to help you so fast."

In December 1981, 202 Johnson Street was sold to the Sisters as a residence; and on July 8, 1982, the Sisters moved for the sixth time, from 225 Johnson to the new residence, where they reside today.

In 1964 the Sisters dramatically changed their habits of more than 300 years, both figuratively and literally, and donned above-the-ankle-length dress. Within four years, clothing style became optional.

The original habit of 1636-1964 had included a big starched bib-like wimple and a headband or bandeau that concealed their foreheads and eyebrows. It had been a copy of the peasant dress of La Flèche, and had become their uniform, with only minor changes over the years, signifying that they were women set apart to serve God in religious life and serving to unite them as a special "family". After 300 years, eyebrows and foreheads were revealed, and it is reported that the older Sisters for some time wore the new headpiece with some embarrassment. The summer of 1968 saw further modifications to the habit. A more simplified dress or suit was allowed without the customary veil.

This was a time of spiritual trial as well as sartorial innovation. Vatican II triggered an onslaught of change, and many Religious left the Orders and the priesthood. It was very painful for those who remained to see the women who had been such an example for them, so well liked, so kind to the patients and so selfless in their service, leaving and looking elsewhere for happiness.

Administrative structure also saw a change in 1965 with the division of certain functions. That of local Superior, held at the time by Sister Gertrude Borden, was separated from that of Administrator, filled by Sister Veronica Callaghan.

A number of the Sisters have inspired affectionate stories. There is, for example, the story of Sister Quilty's ashes. Sister Margaret Quilty, sacristan at HDH, needed some ashes for Ash Wednesday. Ashes were provided by the caretaker at the Cathedral, who burned the old palms to supply the diocese.

Sister kept calling the Cathedral to remind them that she hadn't received the ashes. Father T.J. Raby, intending to pass by the Hospital, offered to drop off a box of ashes for the sacristan at the information desk. A new girl was on duty at the desk, and he handed her the box. She was horror-stricken. The words printed on the top said, in big bold letters, "Sister Quilty's Ashes".

Until the Order became non-cloistered, Sisters did not consume food or drink coffee in public. When the Chapel at HDH was renovated, the confessional was moved from the back wall to the entrance area. At that time a small information desk stood between the Chapel doors and the coffee shop (since moved to the Jeanne Mance wing.) Sister St. Theresa (Catherine Gallery) presided at the information desk. One day she was given a cup of coffee by one of the doctors, who said that even a Sister deserves a coffee break. She decided to find a quiet place to drink the coffee. Shortly afterwards the red light indicating that the priest was prepared to hear confessions came on in the darkened corner of the confessional, but there was no light over the penitent's area, indicating the area was vacant. Father Raby decided he would go to confession, and began, "Bless me, Father." A feminine voice screamed "Stop." Sister St. Theresa had indeed found a quiet place in which to drink her coffee.

Sister Elizabeth Rouble, the chief dietitian, ran a cafeteria that was the envy of hospitals in the province. Patients came to HDH just purely and simply because the food was so good. She would get up very early in the morning, set the yeast for her own bread, and sell bread to raise additional funds for the Hospital. Dietitian Mary McLean has fond memories of some of the desserts made by Sister Rouble. "She was a great baker. Sister Rouble was never happier than when she had her sleeves rolled up and was working at night either making candy or making buns or home-made bread; and then we'd have a sale. We'd have a great bread and bun sale, cinnamon buns, and oh, they were so good! She'd be up at 5:30 or 6 in the morning and still going at 11 o'clock at night. She was a great, great, great person." Funds from the sale went into Sister Rouble's "own little pot of money", and helped purchase silver table services and table linens for banquets. In 1975, Sister Rouble was elected Provincial Superior. Her recipes are still treasured and used at the Provincial House in Amherstview.

Sister St. Jerome (Cecelia Brennan), the inveterate house mother at St. Joseph's School of Nursing, would sit at the desk

in the Jeanne Mance Residence where she could watch the elevator. She used to make the rounds once every hour at night through the building. Students soon learned that if they wished to get into the Residence and use the elevator, the only way was by knowing Sister's schedule for checking the floors. They could come up from the Hospital at any hour through the tunnel from the Hospital to the residence, get on the elevator, and reach the rooms undetected.

THE GENERALATE

May 1949 had seen the first slight change in the habit of the Sisters — it became walking length instead of two inches above the ground. But not only the dress changed. The very manner of governance of the RHSJ had been revised. A Generalate had been formed.

A Generalate has been described as the general governance structure whereby a Council composed of a Superior and assistants is elected by the Congregation. Duly constituted by canonical (church) and civil law, this Council has authority and assures the overall welfare of all the Sisters of the Congregation, as well as the administration of its goods and works, in accordance with the Congregation's own law.

From 1659 to 1845, Montreal was the Order's only North American House. Communities were autonomous, and each was responsible for its own novitiate — and its own finances. However, as the Congregation spread in North America, Sisters found funds short and recruiting difficult. Other Congregations were becoming organized into generalates. As well, the Church had expressed the desire for independent houses of the same Congregation to become centrally organized.

The first whispers of centralization among the Hospitallers were heard in 1919, and a more formal suggestion for the formation of an Acadian generalate originated in the Maritimes in 1926. By 1928 an American generalate was being proposed; and in 1933, a vote among the Maritimes Sisters showed that almost all approved the idea of an Acadian generalate. However, La Flèche was opposed to the whole idea. Rome would not approve an Acadian generalate, but did approve a common novitiate (at the Bishop's discretion).

With the celebration in 1936 of the 300th Anniversary of the founding of the Order, the developing sense of unity among

the North American Congregation strengthened. In France, too, the movement towards union was growing. Negotiation among the Houses continued until finally, in October 1945, New Brunswick formed its generalate, opening the floodgates to change.

By 1948, two generalates were suggested — one French, based in Montreal; and one English, in Kingston; and in 1949 both were approved. The Kingston generalate included Houses in the United States as well as in Canada. The new Kingston-based administrative structure was temporarily housed in HDH's Centenary wing, and moved to a more appropriate home in 1952. On November 16, 1951 the Sisters received the gift of a 12-room house and 400 acres of land in Loughborough Township from Mrs. William C. Scofield of White Plains, New York, to be used for the Mother House and Novitiate. The main dwelling was on Franklin Lake, with several acres bordering Buck Lake.

The formation of the three Generalates — Acadian, Montreal and Kingston — was only a temporary measure. Some communities, such as Windsor, Ontario; Whitelaw, Alberta; and Winooski and Burlington, Vermont, were still autonomous. In 1950 the Acadian Generalate asked for union with Montreal, provided they could retain their autonomy as a Province, their novitiate, and their South American missions. On March 19, 1953, the Holy See approved the amalgamation of all the North American Houses under a single Generalate in what the Annals called the "biggest historic event in our Institute in three centuries." This Generalate, headquartered in Montreal, was initially composed of three provinces. Two were French-speaking: Ville Marie based in Montreal, and Our Lady of the Assumption, in Bathurst, New Brunswick. The English-speaking third, St. Joseph Province, was based in Kingston. Four years later, on May 8, 1957 the official opening of the Provincial House, now in use on 16 acres in Amherstview and overlooking Lake Ontario, across the water from the Amherst Islands, was held. And finally, in 1965, the French and the North American Generalates were united into one single Congregation, the French Houses joining under the name of Holy Family Province.

CATHOLIC SYMBOLISM

Catholic symbolism abounds in the Hospital. The Sisters habits reflected the history of the first hospitals, hostels that offered more spiritual comfort than actual medical care. The garb reflected religious vocation while consisting of everyday clothing of the time. Church-related symbolism continues to be very important. Crucifixes are found throughout the Hospital, and statues in appropriate areas. Even the logo is symbolic. The Chapel dome, built in 1837, gives a sense of shelter or sanctuary; the Latin crosses, Christ's compassion and mercy, and healing ministry; and the double circles show how they radiate to every person. The circles also exemplify the union of staff, functioning as a team or family and interdependent, to serve the patient and each other. They demonstrate the closeness shared in providing sanctuary to those in need.

The logo exemplifies the essence of Hotel Dieu Hospital — faith, love, compassion, strength, endurance and commitment.

Every person in an institution plays a role in the building of that institution. That is of course true for HDH. It is impossible to tell the story of all of the physicians and staff, but some at least of the earlier players should be recognized.

Members of two families of physicians seemed at times almost single-handedly to have provided medical services at the Hospital — the O'Connors and the Gibsons.

The name O'Connor seems to have a certain medical magic in Kingston, four different families with the same name having produced 11 physicians, many of them leaving their mark at HDH. In the early days of medical staff organization, in the 1920s three of the 12 physicians were O'Connors. Fergus J. O'Connor Sr. was Chief of Service for Obstetrics. Francis X. O'Connor was an ear, nose and throat specialist, and Charles E. O'Connor was a specialist in eye, ear, nose and throat. Subsequent O'Connor physicians have included Nicholas (son of Charles); Francis D., his son Laurence and his grandsons John Jarrell and John Smythe (Hotel Dieu Paediatrics); Maurice and Fergus Jr., son of Fergus Sr.; and Fergus Jr.'s son Paul.

Dr. Fergus J. O'Connor Sr.

Born in Long Point, Leeds County, in 1879, Dr. F.J. O'Connor Sr., after teaching school for several years, entered Queen's Medical College in September 1902. Financial problems caused him to withdraw for six months during his third year, but he graduated from Queen's in the spring of 1906. He became HDH's first house surgeon (intern) in 1906 and the first house doctor in 1907, the year he married Frances Keating. He practised in Gananoque for about 10 years, and served for part of that time as the first Roman Catholic Mayor of the town.

He returned to Kingston in 1918 to teach anatomy, obstetrics and gynaecology at Queen's, and until retirement was on the staff of HDH, serving as Chief of Obstetrics from 1924 until his retirement in 1958, and writing a text on obstetrical care. Asked about the special problems of a doctor in the first decade of this century, he remarked, "Well, hitching up a horse on a cold morning. I became something of a horse trader and made as much money trading horses as I did from medicine." He began to specialize in obstetrics in 1924, after Dr. Jim Campbell

burned his hands on an old static x-ray machine in use at the time and turned his deliveries over to Dr. O'Connor. During his years of practice he estimated he had delivered about 4500 babies. He also attended a course in 1922 in Chicago where the first direct blood transfusions were being performed at a time when older doctors still scoffed at the technique. He died April 21, 1971 at 92.

His older son Maurice was a psychiatrist who for a time practised his specialty at HDH. Of six daughters, four graduated from Queen's and two from St. Joseph's School of Nursing. One daughter, Patricia, died as a result of wounds in World War II, and Sheila, the other nurse, also served overseas. Dr. O'Connor's only sister, Madeline, was born in 1890 and was a long-time secretary of the Volunteer Services of Hotel Dieu.

Dr. Fergus J. O'Connor Jr.

Dr. F.J. O'Connor Jr., now retired, served as the first Chief of Paediatrics at HDH. He was the first paediatrician at HDH and was involved in the development of the department when the first beds opened in 1941. He assisted Kingston's medical officer of health in a massive Salk anti-polio vaccination program of 1900 children in all city schools in 1955. His son Paul is also a doctor, graduating from Queen's in 1969.

Dr. Charles Edward O'Connor

Born in 1876, Dr. C.E. O'Connor graduated from Queen's Medical School in 1898. He studied in Vienna and New York, and began his practice in Kingston in 1902. A friend of Dr. William Gibson, he was handsome and dashing and much to the delight of the nursing staff a bachelor, until he married Margaret Burkett in 1935. A great fisherman, he used to present pictures and mounted specimens of his prize catches to the Doctors' Lounge in the operating room area. He had definite ideas about getting as much education and training as possible. He deplored the early marriages of many young doctors, feeling that it forced them into practice before they had had time to complete their education and specialized training. Chief of Eye, Ear, Nose and Throat in the 1920s and 1930s, he had an international reputation in eye surgery. In 1911 he opened the first Eye, Ear, Nose and Throat department at HDH in a suite of four small rooms, where 20,000 patients received treatment and 10,000 operations were performed. Later, a suite of seven rooms was entirely

devoted to eye, ear, nose and throat problems, and fully equipped with the latest and most modern equipment. He died on November 7, 1939, following a gall bladder operation at St. Michael's Hospital in Toronto. His former home at 225 Johnson Street is now the site of the head office for the RHSJ Health System. A second son of C.E. O'Connor, Dr. Nicholas O'Connor, a former resident of Kingston and graduate of Queen's and McGill, is a Boston plastic surgeon who pioneered a skin-grafting technique using test-tube skin that saved the lives of two Wyoming boys at the Shriners Burns Institute.

Dr. Francis de Sales O'Connor

Born in Railton, Ontario, in 1889, Dr. F.D. O'Connor graduated from Queen's University in 1914, and practised first in Tamworth, Ontario. In 1934 he went to New York for a year of post-graduate study in surgery before setting up a general practice in 1935 at 176 Johnson Street. He was Chief of Staff at HDH, and instrumental in establishing it in 1955 as a teaching hospital affiliated with Queen's University. He died on January 8, 1960, in Pompano Beach, Florida. His home at 176 Johnson Street was bought by HDH, initially as the residence of interns and residents in medicine. It is now the Geaganano Residence.

Dr. Laurence Neil O'Connor

Born in 1916, son of Dr. F.D. O'Connor, he became Officer Commanding the 5th Canadian Field Hygiene Section in Italy during the Second World War, and was in charge of five former German military hospitals for a year after the war. He began practising in 1949 in Kingston, after an internship at the Grey Nuns Hospital in Regina, becoming an assistant professor at Queen's in obstetrics and gynaecology, and one of the senior members of the department at HDH. He died of a heart attack on Friday, July 15, 1977.

Dr. Francis Xavier O'Connor

Still another O'Connor, but not a relative of any of the others, Dr. F.X. O'Connor was born in 1886 in Kingston in a house on West Street, a son of Captain Thomas O'Connor. After graduating in 1914 in medicine from Queen's, he joined the 7th Queen's Canadian General Hospital Corps and in 1915 left for overseas, serving in England, Egypt and France as a bacteriologist with the pathological laboratories.

After a stint with the Veterans Hospital helping treat victims of the influenza epidemic, during which Grant Hall at Queen's University was used as a convalescent veterans' hospital, he spent 10 years in New York and New Jersey, specializing in eye, ear, nose and throat. He returned to Kingston in 1927-28 to teach at Queen's and practise in Kingston as an eye, ear, nose and throat specialist from his office at 263 1/2 King Street, where he continued to use the same furniture until his retirement. He became chief of staff at HDH and also taught at Queen's Medical School and St. Joseph's School of Nursing. He died on February 24, 1971 at 85.

The name Gibson also has almost an aura of inevitability in its association with HDH.

Dr. William Gibson

Dr. William Gibson was born in 1879 on Amherst Island, graduated from Newburgh High School, and attended Queen's University, graduating from the Medical School in 1904. He studied vaccine therapy at Johns Hopkins in 1907.

During World War I he was in charge of medicine in the old Sydenham Hospital located where the Eastern Ontario Army Headquarters is situated now. When all patients were transferred to the Queen's Military Hospital, established in 1917, he assumed the same role there.

He was associated with HDH from 1906 to 1942, lecturing and giving clinical demonstrations as well as conducting the clinical microscopy lectures at Queen's University. The one thing he did not like to do, according to his daughter Rose Mary, was obstetrics. He also believed that you should grow into your specialty. "And he did grow into his specialty, and his specialty was heart." He was one of the early members of the Royal College of Physicians and Surgeons of Canada. For many years he was Chief of Medical Staff at HDH, conducting clinics, particularly in the diseases of the heart. He personally gave the Hospital its first electrocardiograph machine in July 1934, and was associate professor of medicine at Queen's until his retirement from the university in 1939. Among his students were the student nurses from St. Joseph's School of Nursing, and he was frequently the speaker at their graduation. He also prepared and gave an annual series of lectures on the Catholic ethics of medicine, to which all students were welcome, and was one of the co-founders of the Newman Club of Queen's, along with Dr. Fergus O'Connor

Sr. One of his sons, Dr. Ed Gibson, also served at HDH. Dr. Gibson predeceased his wife Kathleen Lillian by almost 22 years, dying October 2, 1942.

Dr. James Edward "Ed" Gibson

A Kingston native, he was born in 1915, graduating from St. Mary's Separate School, Regiopolis College and Queen's University, with a B.A. in 1936 and a medical degree in 1940. He did postgraduate studies in Regina, New York, Montreal, Toronto and Kingston. He served overseas with the Royal Canadian Air Force in World War II as a medical officer in York.

Dr. "Ed" was an internist and specialist in medicine, and was Chief of Medical Staff at HDH from 1958 to 1962 and Chair of the HDH Board for many years. He pioneered the development of geriatric medicine, becoming medical director at St. Mary's of the Lake in 1975. He remembered the old student amphitheatre at HDH, built in 1899, as one of the most progressive and modern of its time. It served until 1945 as a teaching theatre where generations of Queen's medical students observed Kingston's best surgeons in action. The custom of having large classes observe surgery became outmoded and it was demolished to make room for the Centenary wing. Dr. J.E. Gibson died in 1974.

Others also played a role in the early days of Hotel Dieu Hospital.

Dr. Isobel McConville

Dr. McConville, born in Kingston in 1866, graduated from Notre Dame Convent and taught school before entering the Kingston Women's Medical College, later part of the Queen's School of Medicine. She was one of six women to graduate from the College in 1889. She was fortunate to have as a mentor and friend Dr. Michael Sullivan, a champion in the 1800s of the rights of women to become doctors. The first and for many years the only woman on the staff of the Hospital, physician to the Sisters, and a specialist in obstetrics, Dr. McConville was at HDH from her graduation until her death in 1947.

Dr. Michael Sullivan

Born in Killarney, Ireland, in 1838, he arrived in Canada at the age of four, and in Kingston in 1844, one year before the RHSJ. He attended both private schools and Regiopolis College

and was one of the first students in the newly-opened Queen's Medical School. He so excelled in anatomy that he was appointed a demonstrator during his first year, in his third year becoming house surgeon at KGH, and graduated in 1858 as the honour man of the year. He was not yet 21. He became Chair of anatomy at Queen's in 1862, revolutionized the teaching of anatomy in Canada by teaching directly from the human subject, and acquired fame as a surgeon. He held the opinion that the proper preparation of a medical student included a thorough grounding in the classics — Latin, Greek and the associated mythology.

Dr. Sullivan joined HDH in 1858 and served the Sisters and their patients until his retirement. He was the first in the area to become an expert in abdominal operations, his first case being an unduly nervous lady. He promised her a new bonnet when she recovered. He did the operation, kept his promise, and bought the bonnet.

By 1866 he became a member of the Medical Council of Upper Canada; in 1870 a member of the Board of Examiners for the province; and in 1883 was elected to the presidency of the Dominion Medical Association. In 1870 he had become Chair of surgery, and concentrated on teaching that subject for the remainder of his teaching career. In 1880, he also took the Chair in anatomy at the newly-established Women's Medical College.

In 1885, Michael Sullivan was asked by the Dominion Government to act as Purveyor-General during the second North-West Rebellion, and while in this capacity he saw the need for efficient hospital service as near the field of action as possible. He served, first at Swift Current and then at Moose Jaw.

He served as Chief Surgeon at HDH from 1858 to 1915, and was a strong supporter of Lister's principles of asepsis. Together with Dr. E. Ryan, he built the surgical amphitheatre where he gave lectures.

He also served as alderman for Sydenham Ward in Kingston, was elected as Kingston's Mayor in 1874, and once contested Kingston in a federal election, being defeated by a very small majority. A life-long friend of Sir John A. MacDonald, on January 29, 1884 he was appointed to the Senate, becoming one of its most active and respected members. Dr. Michael Sullivan died on January 26, 1915, receiving the unusual tribute from Queen's University of an academic funeral.

Dr. Joseph P. Quigley

Born in Kingston in 1881, he attended KCVI and Regiopolis. In 1903 he graduated from Queen's in Arts, and in 1907 in Medicine. He came to HDH as the Hospital's second intern in the fall of 1907. From 1908 to 1909 he studied at Whitechapel Hospital, London, England, specializing in radiology and x-ray, which was relatively new at the time. Dr. H.A. Boyce, then Superintendent of KGH, did the radiology for both hospitals at a very early stage in the development of this technique. In 1909 Dr. Quigley returned as a general practitioner and specialist in x-ray and radiology.

During World War I he served at #1 and #7 Canadian General Hospitals in Etaples, France, in the Mediterranean, and in Egypt where they had to construct their own coil-type electric generators for the x-ray machines, a task requiring considerable ingenuity. On his return, he assisted in running the Queen's Military Hospital, and then became Chief Radiologist at both KGH and HDH. He taught radiology, Materia Medica and some medicine at Queen's, and became one of the charter members of the Royal College of Physicians and Surgeons of Canada. He was said to have been a great teacher with unlimited energy to demonstrate, interpret and discuss radiology with anyone willing to learn.

HOSPITAL LEGENDS

Also important in the story of any institution is the oral history — the legends and the tales — and HDH has its share. Although some of the stories could be attributed to the sudden appearance of one of the Sisters in her long white habit on the wards at night, the Hospital is said to have at least one ghost, a particularly peripatetic Sister.

The story has been extant at HDH for a very long time. Windows would fall down without reason, lights turn on and off with no-one in the room, at first in the Sydenham wing, then in the Johnson wing and then in Jeanne Mance, always on the third floor. Many of the nurses would say during these strange occurrences, "There she is again." The ghost is said to be that of a deceased Sister, but there is no record of her name. A similar "Sister" ghost was also reported on Brock 4, when sometimes at night the nurses would hear someone moving around in empty rooms. She was also said to have walked about the nursing

student dormitories in the early 1940s. She may still be at HDH — there is a report of her having been seen in the early 1990s on one of the nursing floors.

The legend triggered a somewhat more substantial "ghost". Rita McAvoy, a nursing student in the early 1940s, dressed up as a nun one evening and went through the dorms. "I went into a couple of rooms, and then into the little apartment where there were four girls. One of them said, 'If she goes through that wall we're going out the window!' I couldn't manage to go through the wall," she said with a laugh.

A second ghost, according to one source, may have been that of Henrietta "Hennie" Oberndorffer who once did the shopping and banking in the 1930s and early 1940s for the Sisters, at that time still cloistered. The Sisters for many years would care for those in their old age who had cared for them. Hennie and her sister Esther, still living in 1942, had a suite on Brock 5. Their family operated a business in town, and their brother used to come regularly to visit them. Sister Audrey Mantle remembers them clearly. "Esther was short, white-haired, and somewhat crippled with a bad foot. She used to stick her head out the door of the room to see what was going on. She was very nice. Hennie was thin as a rake, taller than her sister, and wore her hair in a Gibson girl bun on the top of her head. She wore really nice clothes, elegant in the old-fashioned sense of the word, and glasses, pince-nez, I think."

Another ghost may have been that of Minnie Hanley, born in Kingston. Her brother Dr. Robert Hanley was a well-remembered medical man; and a second brother, Rev. Archibald Hanley, for 17 years was Rector of St. Mary's and for seven years chaplain of HDH. Minnie trained as a nurse in New York, and on her return to Kingston was hostess and housekeeper for her father and brothers. The stained glass window of the Holy Family over the main altar at St. Joseph Provincial House was donated by Miss Hanley in 1957. For a number of years until her death, she lived on Brock 2 in room 227, with her pictures, some of her furniture, her mementos and her memories around her. Wearing very thick glasses and claiming she could not see very well with one eye, she used to laugh and say, "One of my friends says 'Minnie, you see altogether too much out of one eye.'" On Brock 2, St. Michael's corridor, if lights would come on and nobody was in the room, the nurses always said that she was there just checking on them.

But there's a possibility that the ghost on Brock 2 may have been still another Minnie. Another Hospital legend claims that the ghostly Minnie was one of the orphans who had stayed and worked with the Sisters.

One of HDH's most beloved characters was Mary Bradley. Originally from Ireland, she worked on a farm in the Kingston area and was badly scalded. Brought to HDH as a teenager and nursed by Sister St. James, she soon became a Catholic. She worked in the operating room, the Pharmacy, and finally on the Switchboard, often protecting interns and nurses when leaves extended beyond curfew time. Between switchboard calls she often scrubbed the entrance, halls and the elevator. She retired from Hospital work in 1966 and came to live permanently with the Sisters in 1967. She spent many hours in the Chapel, and could often be found with her head bent on the back of the pew having a light nap. On August 29, 1975, the Hospital lost this life-long friend. She would have been 86 on October 17.

MEDICAL EDUCATION

Since its foundation, HDH has worked closely with the Faculty of Medicine at Queen's University to provide medical students with proper education. Early physicians on staff, some of whom interned at HDH, included those described as Hospital legends, as well as Charles Morrison, G.W. Mylks Sr. and Jr., Daniel Phelan, I.G. Bogart, C.A. Howard, Basil Koster, Kenneth Regan, Maurice James, William Amodeo and Harry Warner.

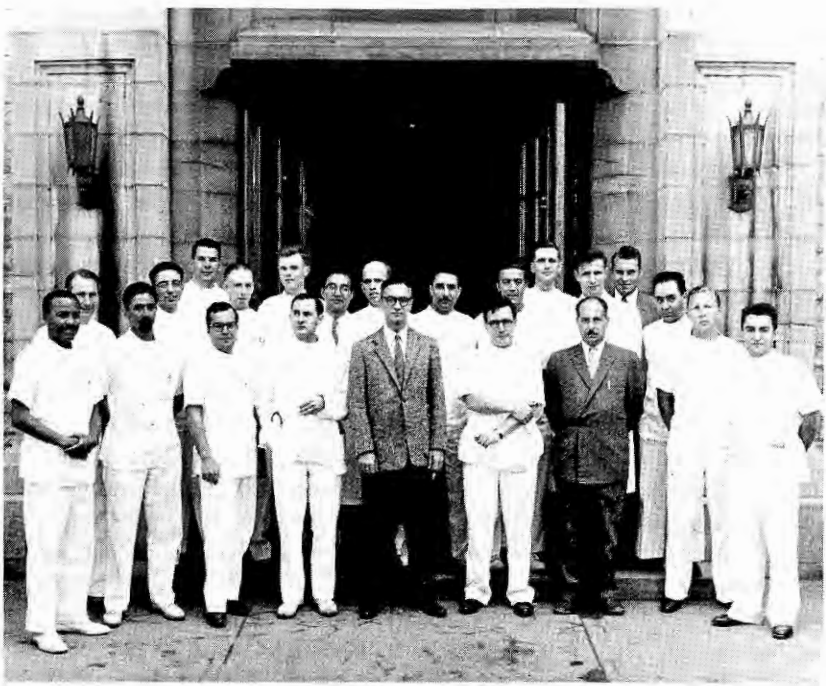
Training was not limited to the medical faculty. In-service education is vital in every hospital. Nurses returning to work after raising their families need to have skills sharpened with, in 1970, a 14-week refresher course. Nurses need to know how to use electronic monitors in the intensive care or renal dialysis units, and be knowledgeable about auto-immune diseases and hyperbaric chambers. As technological breakthroughs are announced, new techniques and equipment develop and continuing education becomes a way of life.

Surgical nursing courses have been given at HDH since 1957 to train specialist operating room nurses over a six-month period in operating room technique and management. Most of the surgical staff are involved. Enrolment is usually five or six. The Hospital runs one course per year over a period of about six to eight months, with lectures in general surgery, orthopaedics, otolaryngology, gynaecology, urology, ophthalmology, plastic surgery, cardiothoracic surgery, pathology, anaesthesiology and oral surgery, as well as operating room practical experience, with supervision. It is the only course of its kind in Ontario. Students attend from as far away as Vancouver and Hong Kong.

In 1990 the Board of Directors approved a Nursing Education Trust Fund to help nursing personnel gain higher academic qualifications and keep abreast of changing technology and expertise. Proceeds from the Christmas "Festival of Trees" given to the Jeanne Mance Foundation supported the target amount of $500,000.

Staff also need to be trained. In 1960, a training program for orderlies was established as part of an In-Service Program. Finally, as described in the section dealing with the Chaplaincy and Pastoral Care, all new staff attend the special "Share the

Process" program that teaches them about the mission and values of the Hospital and the history of the Sisters.



Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

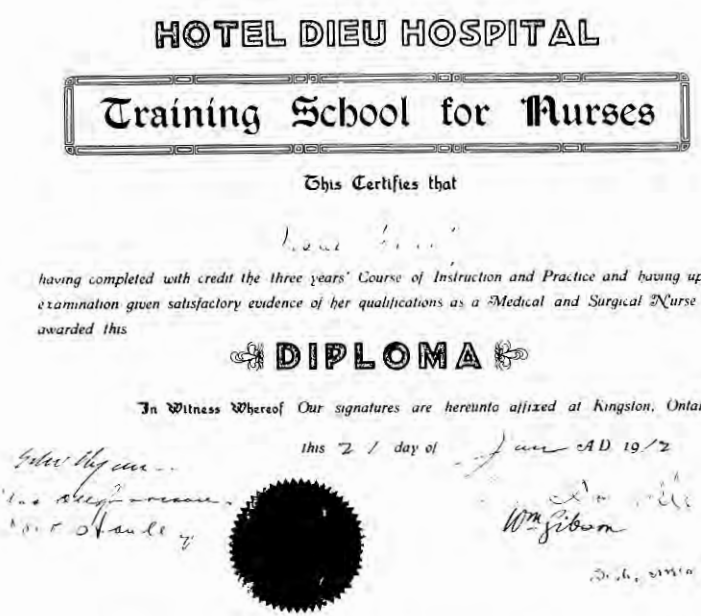
Interns, residents and staff, 1961.

HDH education reaches outside the Hospital itself. On October 3, 1961 a three-day course was offered to bring local family physicians up to date on new methods and techniques and make them better equipped to deal with anaesthetic problems where anaesthetic specialists were not available. On October 18 of the same year, a series of post-graduate lectures to run yearly through the University year was attended by both doctors and interns. On November 1 a three-day conference, jointly sponsored by Queen's University and HDH and partly financed by the Ontario Heart Foundation, acquainted family doctors with ECG machines and methods. Registrants came from Toronto, Napanee, Brockville, Belleville, Kemptville, Whitby and as far away as Labrador, as well as from Kingston.

Various divisions in the Hospital also play an important role in the Queen's University Continuing Medical Education program.

ST. JOSEPH'S SCHOOL OF NURSING

Education in all phases of health care has always been a priority at the Hospital. St. Joseph's School of Nursing, under the supervision of Sister St. Charles accepted its first applicants and opened in September 1912, with an enrolment of eight students for a three-year training period. The final set of provincial examinations was written after the end of the course. The first students included Anna Legree of Cornwall, the first graduate to marry an intern, Dr. A. Cauley of Hamilton; and Margaret Mary O'Keefe of Peterborough, who became Director of Nursing in 1918 and entered the Order in 1920 as Sister St. Oswald.



HOTEL DIEU HOSPITAL

Training School for Nurses

This Certifies that

having completed with credit the three years' Course of Instruction and Practice and having upon examination given satisfactory evidence of her qualifications as a Medical and Surgical Nurse is awarded this

DIPLOMA

In Witness Whereof *Our signatures are hereunto affixed at Kingston, Ontario, this 21 day of June AD 1912*

Wm Gibson

Courtesy of Religious Hospitallers of St. Joseph, St. Joseph Province Archives

St. Joseph's School of Nursing certificate, 1912.

Programs and Training

In the early days of training students worked directly with patients in clinical areas for 58 or more hours per week. They worked two shifts of 12 hours, with one hour off during the day for a walk or a rest. The night shift was from 7 p.m. to 7 a.m., including a few minutes for lunch when possible.

They attended class in the 30-seat classroom on the ground floor of the Brock Street building. Lectures were given by doctors, including W. Gibson, R. Hanley, McCarthy, McConville, Morrison, C.E. O'Connor, Phelan, and Ryan. The first graduation of lay nurses took place in 1914.

Students attended classes in the 1920s in the classroom across the courtyard from the recreation room, on the east end of the first floor of the Brock Street wing. By then, students worked 12-hour shifts with a half day off per week. Members of the medical staff lectured to the students, usually after 7 p.m. when students were off duty or at supper time after the doctor had finished his office hours. Most training was done at the patients' bedsides by the floor supervisor and Superintendent of Nursing. At first, there was no established curriculum. Students received training in medical and surgical nursing, and maternity and operating room services, and spent a term in the diet kitchen. In the early 1920s, some classes were affiliated with the Mowat Sanatorium for tuberculosis patients under the Department of Health. Later in the 1920s when this affiliation ended, the tuberculosis ward was established at HDH. Students also lived in for two months in the isolation area at KGH, as part of another program of affiliation. The Class of 1938 was the last to affiliate with KGH for isolation training in tuberculosis and communicable diseases.

In 1922, an Ontario registration law required students to write departmental examinations on completion of their course, and to register with the Department of Health. To meet these requirements, clinical hours decreased to make room for more classroom time.

Also in 1925, the first married woman, Mrs. Marjorie Ryan, a widow with a little girl, was accepted. Her daughter lived at the nearby Congregation of Notre Dame convent while her mother was at nursing school.

The large dome above the Sydenham Street wing contains a large unfinished room once used by nursing students in the 1920s and early 1930s to make Hospital supplies such as

dressings, cotton balls and applicators, which were then sent to the main operating room to be sterilized. The operating room, built in 1899, was on the corner of Johnson and Sydenham, the area now called Centenary wing. Gauzes used in the operating room and contaminated with "clean blood" were sent to the laundry to be washed, and then folded and packaged in the dome and sterilized for reuse as compresses.

Jeanne Mance Pledge

That I may be strengthened in my resolve to model my life of duty after that of Jeanne Mance, the first lay nurse of my beloved Canada.

I place myself in the presence of God, and I pledge myself with the help of His Grace, to be faithful to the following ideals:

I will be true to the practice of Religion which is the inspiration of my noble vocation, and while administering to the body will serve the soul, by observing the principles of right ethics and nursing honor.

I will be devoted to the profession which is mine; obeying the physician within the sphere of his authority, and I will make my work a labor of love rather than of profit, whenever the service of God or country requires it of me.

Rev. J.P. Sullivan, Hospital Chaplain from 1938 - 1949, compiled the Jeanne Mance Pledge in 1943. It was recited by the graduating nursing classes from that year forward.

In 1931 Sister Gertrude Donovan and Sister Mary Immaculate (Sarah Kathleen Kennedy) studied nursing school administration at the University of Toronto. The same year the School was notified that it was on the approved list of training schools, a designation it retained until its closing in 1973. Sister Donovan was a long-time Director of the School and later Administrator of the Hospital.

Students were able to take advantage of the new classroom in the St. Joseph's wing, which opened in 1931, and could study dietetics in the new diet kitchen between the residence and the Brock wing. They still worked long hours. Their day began at 5:45 a.m. to get ready for Mass at 6:30. The work day began at 7:30 and ended at 7 p.m., with one half-day off per week. Once a week, all were permitted to sleep in until 6:30. Until 1933, the students provided their own uniforms. They received an allowance of $3 per month during their first two years, raised to $4 per month during their final year. Out of this allowance, however, they were required to pay for "breakage."

Post-operative patients were still kept in bed for seven to nine days, and hernia patients for 14 days. One day Dr. Howard removed the appendix of an 18 year old boy. That evening, much to his alarm, the boy got out of bed and ran the length of the corridor, becoming possibly the first patient to get out of bed on the day of surgery. (The boy recovered.)

The Sister who was to assume responsibility for the nursing unit for the day visited briefly to check her patients before attending Mass in the Chapel. At 7:30 she returned for the morning report with the night nurse and day staff.

Nursing care during the period of the Second World War was more personal than today, according to Ann Ryan Ferguson who entered the School in September 1940. "It was simple TLC, really, with a little bit of theory thrown in. Our initial three months of training was learning how to make a bed and bath a patient, and that hands-on sort of thing, and that's what nursing was. It was tender loving care of the sick." The student was usually responsible for patients in selected beds who became her complete responsibility for care, medication and treatments. "You went in in the morning, you got them ready for breakfast, you gave them their breakfast, you gave them their medications, then you gave them their bath or whatever care they needed, and you did this for each one of the patients that you had." Assignments did not rotate. There were no group rounds. The

student or the senior nurse accompanied the doctor on his rounds, and the nurse had a complete clinical picture from admission to discharge. Classes, taught by Hospital personnel — doctors, interns, priest, department supervisor — were held in the new classroom in St. Joseph's wing.

From 1940 to 1946, the student lived a 12-hour on-duty, 12-hour off routine, with shifts from 7 to 7. If the work load allowed it, the student received two hours off at some time during the shift. Roll call was every morning at 6:20, except when a general sleep-in was scheduled, and students then proceeded to morning Mass. Night duty nurses gathered in the Chapel before going on duty, and students approaching graduation attended retreats. During the school year, daytime hours off were usually spent in the classroom from Monday to Friday. Once a week the student was allowed a half-day off duty. If it was in the morning, she could sleep in, reporting to work at noon. In the afternoon, if her work was up to date, she could leave her nursing unit at 1 p.m.

Sometimes it wasn't easy staying awake on the night shift, and Ann Ferguson remembers, "We had a real dream of a nun, Sister Callaghan. She was kind. You never got caught snoozing, because you could always hear her keys and prayer beads rattling as she came down the stairs from fourth to third. I think she did it on purpose so that you would know that she was coming."

The first lay assistant to the instructress of nurses, Mrs. Betty Kipkie, a class of '37 graduate, was appointed in the fall of 1943. Mrs. Kipkie later helped to establish the Hospital's first Central Supply Department.

From mid-September 1946 to 1959, the curriculum was reorganized into the block system. Probationary students attended class from September to Christmas, 8 a.m. to 6 p.m. Monday to Friday. Alternative weekends they were either on ward duty or enjoying time off. The other two classes worked 8-hour tours of duty with a half day off per week. In January and February the intermediates attended classes, the senior students in March and April, and then junior students finished the school year with another eight weeks of classes. The block system helped St. Joseph's School of Nursing to become a teaching unit of unsurpassed reputation, regarded in 1950 as eastern Ontario's leading Catholic School of Nursing.

At the same time, faculty numbers increased, and plans were in progress to provide a new school and residence for the nursing students. No longer were 12-hour shifts the norm. During 1947 classes expanded. The Centenary wing was in the final planning stages and the Jeanne Mance Residence being built. Until its completion, some students were housed in one wing of St. Mary's of the Lake Hospital and commuting back and forth by the legendary "Black Maria" driven by Tim Downey. In 1947 the Queen's Baccalaureate nursing program began. Sister Mary Coderre, '41, was one of the first students, followed by Sister Audrey Mantle, '42. Following graduation from Queen's, both Sisters taught in St. Joseph's School of Nursing. In the years following, more and more St. Joseph's students took advantage of the Queen's program.

By the end of 1949, the 8-hour day and 48-hour week with an annual vacation was introduced for nursing students. Moreover, admission standards were high. During the preliminary period, a minimum average of 75 percent was demanded; in other years 60 percent. Behavioural standards were high as well.

The need for better education for instructors and supervisors as well as nursing students prompted more and better clinical experience. Many students were affiliated for psychiatric nursing for three months with the Ontario Hospital, now Kingston Psychiatric Hospital, and for six weeks of tuberculosis nursing with Ongwanada Sanatorium. Due to class size and the small HDH Paediatrics Department, some also had the opportunity to affiliate with the Children's Hospital, Montreal.

Responsibility began early. Most intermediate and all senior students were placed in charge of a ward in the afternoon or night shifts - 3 p.m. to 11 p.m. or 11 p.m. to 7 a.m. However, a senior supervisor could always be asked for help or advice.

The 12-week main operating room duty period was gruelling. The junior student arose at 4:30 a.m. to 'prep' the surgical patient. She worked all day and visited all new pre-op admissions in the evening to obtain signatures for permission to operate. She was also subject to a 24-hour call system.

Until 1957, nursing service and nursing education were combined under one director. In 1957, the Director, Sister Margaret Mooney, established a Nursing Service Office under the direction of Sister Mary Coderre, '42, and Monica Hanley, '54. The School was governed through the Nursing School Advisory Board and the Student Council. However, in September 1960 the

Nursing Service Department split from the Department of Education, and Miss Anne Marie O'Toole became Director. Sister Loretta Gaffney succeeded her in 1963. It began a period of enormous changes in the program, in the discipline, and in the way of life for the nursing students. Also in 1957, the Advisory Board approved an annual $100 scholarship in post-graduate nursing.

The Parent-Teacher Association was established in 1958 to provide parents with the opportunity to meet teaching staff and discuss academic progress and residence regulations, and was at that time the only such Association in the province.

Turbulence and change were the keynotes of the 1960s. Enrollees in 1960 spent the first four months in class, and two months in their senior year. Instruction in obstetrics, paediatrics, operating room techniques, orthopaedics and general medical-surgical nursing were given concurrent with clinical experience in the appropriate areas. Students were on duty 48 hours per week, including considerable night time and classroom time. But conditions were extremely crowded in the Hospital. The rumpus room was converted into a large practice ward, with equipment loaned by Ongwanada Hospital.

By the mid-1960s, students received a stipend of $15 per month, and now enjoyed a 5 1/2 day work week. By 1964, nursing students were spending seven months in academic study during their first year.

In the mid-1960s the School sought community involvement, and the St. Joseph's School of Nursing Administration Committee was formed with representatives from the community. In 1966, the School established a 2 + 1 program, linking two years of theory and clinical practice with a subsequent year of internship. By the end of the decade, a 35-hour work week was introduced, and late passes became a thing of the past when an honour system for late hours was introduced.

School administration changed as the provincial government, through the Ontario Hospital Services Commission, began to share the fiscal responsibility for providing medical care with Ontario hospitals. Budget subsidies were introduced. Now with its own budget, the School achieved some independence from the Hospital. Nursing education became standardized when the College of Nurses of Ontario was organized in 1962.

The School graduated its 1,000th nurse, Elizabeth Ann Cassidy '61, on the 13th of May. The first Hospital-sponsored student from Peru, Emma Ortiz, was welcomed in 1963.

The curriculum also changed. Before 1963-64 practical experience in obstetrics or paediatrics was gained some time after theory was taught. The change saw theory being taught concurrently with practical experience. The stay in the diet kitchen was cut from six to four weeks, and those in the operating room worked six weeks of day shift with weekends off. The Class of '64 found RN exams totally multiple choice and marked by computer. Clinical instructors could now assign suitable patients to sharpen a student's skills — and many more skills had to be learned. The medical intensive care unit had expanded and was now equipped with new life-saving devices.

St. Joseph's was the first school in Ontario to provide its students with a six-week geriatric nursing experience, beginning in 1965, at St. Mary's of the Lake. Rather than serving in the Diet Kitchen, students now counselled patients about their diet; and gained experience over a two-month period at Kingston Psychiatric Hospital. They also became familiar with nursing procedures in each Hospital department through a system of rotation.

The 1960s were years of turmoil — the 1970s breakneck change.

The classes of '69 and '70 studied a transitional curriculum. The class of 1970, which graduated on September 11, was the last registered in the traditional three-year program. The first nurse interns were members of the class of '71. The 2 + 1 program was only a transitional phase. In August 1972, two classes graduated. One was the second and last group of nurse interns who had enrolled in 1969.

Those who enrolled in 1970 expected to follow the 2 + 1 program. However, in late autumn a government directive provided for dropping the year of experience, and the second class of '72 contained the first graduates of the new two-year program. The same class also included the first male student to enrol and graduate from the School, Henry Yip-She Lam, from Hong Kong. In all, at least three male students were to graduate from the School.

In the 1970s, students gained experience in the medical, surgical, obstetrical and paediatric units of HDH, at St. Mary's of the Lake in rehabilitation and geriatrics, in Kingston Psychiatric

Hospital, with retarded children at Ongwanada, and in a small hospital setting with Lennox and Addington County General Hospital in Napanee. They also observed the operation of a number of community agencies providing health care.

The Class of '73 were among the first nursing students in Ontario who were expected to pay tuition fees, $250 per year. They were provided with subsidized board and lodging, and received $40 month as a food allowance. This class was the last class to graduate from St. Joseph's School of Nursing with their training fully provided by the School.

In January 1973 the Ontario Ministry of Health and the Ministry of Colleges and Universities decreed that all diploma nursing programs in Ontario were to transfer their teaching programs into the general education system to become part of the Colleges of Applied Arts and Technology, effective September 1, 1973.

The move of the School from Hotel Dieu to St. Lawrence College was very difficult for many people, according to Mrs. Norma Struzzo-Jones, the last Director of the School. The move involved numerous meetings with the Directors, teachers and administrators from the other existing schools in the city, including those at Kingston Psychiatric Hospital, Queen's, and KGH. Also involved in the planning process were those from the institutions used for clinical experience: the Public Health Units, Victorian Order of Nurses, St. Mary's of the Lake.

The Class of '74 spent its first year at HDH and the Jeanne Mance Residence, and then joined other students on the Kingston campus of St. Lawrence College. They formed the last group of alumnae of St. Joseph's School of Nursing.

Uniforms

When the School first started, the pale blue uniforms were almost floor length, with a starched white apron, bib and cuffs. As programs and social mores changed, so did the uniforms.

The 1920s student uniforms were shorter, ankle-length blue chambray with long sleeves, shorter starched white cuffs, and a stiff high Roman collar, fastened at the front in the summer and at the back from November to May. When working, the white cuffs were removed and the sleeves rolled up. A white apron covered the dress, and after the three-month probationary period students also wore a belt, and a bib and cap with a full

section at the back that was shirred to a white band. Black shoes and stockings were worn for a brief period, but were replaced by white.

With the bobbed hair of 1933 came a simpler cap style. The long sleeve was shortened to above the elbow, with a stiff button-on white cuff. The length of the skirt changed, but was always longer than street dress.

The uniform during the Second World War became a short-sleeved blue shirt dress with white collar and cuffs. During the probationary term, usually four months, students wore a white apron. On "capping" day, a stiff bib and belt were added, and white shoes and stockings completed the uniform. In 1953 the capping ceremony which marked the end of the probationary

Courtesy of Religious Hospitallers of St Joseph, St Joseph Province Archives

L-R Margaret Cantarutti '65, Beverley Grant '73, Margaret Little '57 with painting of Jeanne Mance, 1973.

period by removing the veil and completing the uniform with cap, bib and belt, was modified to become a Striping Ceremony. The probationer wore a plain cap with her full uniform, receiving a yearly diagonal stripe. The Class of 1959 was the last to wear the "blue job".

The uniform changed four times in the 1960s, and a new school cap was introduced. A white wrap-around uniform bearing the School crest on the left sleeve was tested for two classes. For three classes, a white A-line dress buttoned up the front and with the crest on the left shoulder provided comfort if not glamour. Probationary students in 1967 boasted a newly-designed blue and white striped uniform with starched collar and cuffs and the School crest on the left shoulder. The sweeping lines of the new cap symbolized rapid and constant change in the field of medicine, and the triangular back the three-fold foundation of nursing skill, knowledge and love. In 1969, in the last uniform change, students donned a perma-press A-line dress with lighter blue stripes.

Housing

In 1912, the students lived in the Brock Street apartments, part of the original HDH of 1845, and on the ground floor of the Sydenham building in a large airy dormitory with 10 beds, a dining room with small kitchenette for evening snacks, and a recreation room. Dorm rules included lights out and silence after 10 p.m. each night. Students attended morning Mass at 6:30 a.m.

A student was required to bring her own cutlery, linen serviette and serviette holder. Students on day shift slept in the dormitory. Those on nights slept in the Brock Apartments.

Construction of a new nurses' home across a courtyard from the Brock Street wing began in the 1920s and was completed in 1927. In those days, the 10 p.m. curfew was strictly enforced, late leaves were almost non-existent, and early morning roll-calls were compulsory. Social contact between student nurses and student doctors was forbidden. One student who went to a dance with an intern had to perform an extra month's duty. In spite of the long hours, students led a very active residence life. Since 1929, HDH student nurses had been active members of the Queen's University Newman Club. In 1934, during the depression, students established the Jeanne Mance Guild to supply trained nurses for those who could not pay, and

provide full-time night-duty nurses for seriously ill indigent patients in the Hospital. In 1938, the students formed a literary club, publishing a bulletin, "Mance", until 1941. They also enjoyed an athletic club, a glee club, a drama club and a social committee as well as a Sodality (a type of fraternity).

Students became involved in many activities associated with World War II, in 1940 raising $700 for the Nurses' War Fund Committee. Thirty-six nursing sisters, new graduates as well as experienced nurses, joined the Services.

In the 1940s, Hospital demeanour and residence life revolved around discipline and morality. Students disobeying School or Hospital rules were dismissed, as were student nurses who married. Lesser infractions could mean suspension. Inspection of both uniform and street dress was routine, and slacks and shorts were forbidden. The Director of Nurses inspected each student's uniform before she could proceed to the wards. Each student nurse was allotted three 12 o'clock passes per month. In each successive year, a one or 1:30 a.m. leave was granted. Otherwise, the deadline was 10:30. Social life was restricted by the duty hours, but a sense of community developed among the students. "We were in the dorm in our early first year," says Ann Ryan Ferguson, a '43 graduate. "We only had one bathroom to a floor with 20 or so rooms on a floor, so we learned to live together very closely. On the night of a prom there wasn't time for each one to have a single bath, so two or three, or three or four of us would share the tub at the same time because that's the only way we would get it."

In 1948 the first two floors of the Jeanne Mance Residence opened and in 1952 construction began on the top four storeys. Marilyn (Jones) Braden, a student nurse at the time who later became President of the Alumnae, Alumnae representative to the Nursing School Administration Committee, and Vice-Chair of the Board of Trustees (1979-80), vividly remembers those days. "Within my first year our building was constantly bombarded with workmen and jackhammers and backhoes. I remember working the night shift and being awakened in the middle of the day with a jackhammer under my bed." Because they had lived through the construction, her class was the first to actually live in the new accommodation in Jeanne Mance, on the third floor. "We thought we were in seventh heaven." The top four storeys of the Jeanne Mance Residence were finally completed in 1955.

Sister Bernice Hughes served as Superintendent of Nurses from 1942 to 1952, and Sister Aileen Byrnes as Director from 1952 to 1956. In the 1950s, all the students enjoyed the autumn formal and the spring Graduation Ball, as well as assorted picnics, class parties, alumnae dinners and the social functions at the Royal Military College and Queen's University. Just before the Christmas party, the Ringing festivities marked the occasion when the senior class received their rings.

Slowly, in the 1960s rules of the Jeanne Mance Residence relaxed when an honour system was tested, and more late passes were provided. Students now had a general one o'clock late leave, and an automatic two o'clock before any days off. A full honour system came into operation, and students could marry at any time and live outside the residence.

Although during the 1960s many changes had taken place, in fact nothing of real importance had altered. Patients still received the same high calibre of nursing as in the past.

By the 1970s, residence life had been transformed. Students had a freedom undreamed-of in earlier days, but were expected to act in a responsible fashion. Students participated on committees dealing with aspects of nursing education, and an honour discipline committee dealt with any disciplinary problems. The only curfew was a self-imposed one.

Over the years, the Ladies Auxiliary took a special interest in the nurses being trained at St. Joseph's School of Nursing, and in 1973 the Auxiliary presented pins to the 60th and last class of nurses to graduate from HDH.

The Hotel Dieu Nurses Alumnae

The Hotel Dieu Nurses Alumnae was formed on February 21, 1922, with Miss Mae Gibson, '16, as president and with about 50 graduates. Miss Gibson had been one of six Canadian nurses in Halifax during the famous Halifax explosion, and later served overseas during World War I. On her return, she became Matron at the Prison for Women.

One of their first efforts was as hostesses when the new nurses' home was officially opened on October 16, 1923. Alumnae provided treats at Easter, Halloween and Christmas. For many years, among other events, they held a Rose Tag day yearly for projects which included dinners, receptions and graduation dances. An Alumnae donation of $1,000 provided the furnishings for the new classrooms in St. Joseph's wing, and in

1945 the Alumnae sponsored a mammoth luncheon to commemorate HDH's centennial. Alumnae provided drapes, furniture, books, microscopes, even a piano, for the Jeanne Mance Residence.

Among many Alumnae gifts to the Sisters was a gold ciborium now used in the Chapel of the RHSJ in Amherstview.

By the 1960s, Alumnae branches were formed on the West Coast and in Toronto and Ottawa. For the Johnson Street wing, alumnae pledged $10,000, a pledge honoured within a five-year period; and they staged a gala reunion in 1966 to celebrate the fifty years since the first graduation in 1915. In the late 1960s, having given more than $20,000 to the School and to HDH over 50 years, the Alumnae decided to concentrate on the social rather than fund-raising aspects; and in 1972, to celebrate their Golden Anniversary, brought together hundreds of graduates from across Canada and the United States. The current president, Mrs. Margaret Cantarutti '65, has served in that office since 1971.

Today, its chief function is to organize graduate reunions. With the transfer of the School to St. Lawrence College in 1973, the need for more active alumnae ended. There are now about 1,400 alumnae, whose memberships help to fund an annual scholarship at St. Lawrence College, originally a St. Joseph's School of Nursing scholarship.

The Hospital maintains membership lists under the jurisdiction of the membership chair, since this has become the focus of graduates seeking information. "The maintenance of a membership list and the sponsorship of an annual reunion provides a cohesiveness for graduates of this institution. It became more important than ever with the closing of the School," says former president Marilyn Braden.

Alumnae are still proud of their heritage.

SCHOOL OF MEDICAL TECHNOLOGY

In any hospital, there is a need for laboratory technologists to analyze body fluids, prepare tissue samples for analysis by the pathologist, perform chemical and haematological analyses, and check bacterial samples.

The Canadian Society of Laboratory Technologists was formed in 1937, and the first training school began in Hamilton shortly afterwards. At first all training was hospital-centred; and

many of the larger hospitals began to train their technologists. In 1949 the Canadian Medical Association approved the formation of a School of Medical Technology at HDH. Dr. John Tweddell, assisted by Sister Loretta Gaffney, registered the first class on September 6 — Sister Mary Rosalia S.P., and Miss Pauline Champagne. By 1952, four technologists had registered. At that time the program lasted 14 months, with a requirement of Grade 13 education including two mathematics and two sciences, one of which had to be chemistry. "Our program was mainly on-the-job training," said Margaret Thompson, who entered the program that year. "The pathologist gave some lectures. We trained in biochemistry, histology (the pathology of tissues), haematology, bacteriology, urinalysis and blood bank." Students also received some training in public health issues.

Students lived at home or in a rooming house, and ate meals in the cafeteria. They studied and worked 5 1/2 days a week, often working split shifts with the evening shift ending mid-evening. "After that, the Sister who was in charge of the lab did all the calls." Training did not end after graduation, Margaret pointed out. In the 1960s, more advanced training was done "at home, on my own." Technologists attended lectures at Queen's given by visiting professors. Training in new equipment was given by the company supplying the equipment.

In the early 1950s the Ontario Society of Laboratory Technologists was established, but examinations and curriculum still remain under the Canadian Society, and registration is valid throughout Canada. At the same time, to attract more registered technologists, the provincial government began paying a student stipend.

By 1970 training lasted almost two years, and included clinical chemistry, haematology, histological technique and some histology, microbiology, urinalysis and blood banking. Much of the training was given by the Hospital's pathologist, clinical microbiologist and clinical chemist. Laboratory technology still included many manual techniques, whereas today it is highly automated and computerized. "Students no longer have the pleasure of doing a test and measuring out the various ingredients and mixing them up and spinning them and heating them and seeing the colour change and all the rest of it," said Winifred "Winnie" Smith, the teaching technologist from 1970 to 1974. "You used to count all the blood cells, the white blood counts

and the red blood counts. It takes a lot of patience and it's tricky. There was quite an art to it."

Six students with Grade 13 education were taken into the course each September, and graduated in June one and a half years later. "I usually interviewed about 60 students for the six places. I always tried to find out whether they had had anything to do with a team or had had some sort of part-time job. I wanted to know whether they could fit into a team, because lab work was teamwork. To my mind this was the most essential thing," said Winnie. Graduating students wrote the national examinations for the Canadian Society of Laboratory Technologists in the October following graduation, and, if successful, earned their R.T. for Registered Technologist.

In 1975, St. Lawrence College took over the training of medical technologists, and the Hotel Dieu School closed. The stipend paid by the Ontario government to students was also terminated.

SCHOOL OF MEDICAL RECORD LIBRARY SCIENCE

Good health care is partially the result of a good medical records system. One of the first schools for medical record librarians in Canada was begun by Sister Florence Campion at HDH, after attending a Chicago workshop in 1934 of the Association of Record Librarians of North America. She then received instruction in the most scientific methods of medical record keeping at St. Vincent's Hospital in New York City; and on her return home she started a program to teach students the new methodologies.

At a meeting in Toronto on October 15, 1935, she established the Ontario Association of Medical Record Librarians. Its stated purpose was "to improve the standard of clinical records in hospitals, dispensaries and medical clinics; to serve as a means of intercommunication among Record Librarians; and to encourage the training of Record Librarians to the end that they may render intelligent service in that capacity and thus assist in the promotion of efficiency and spirit of cooperation in hospitals."

In 1935, the schools at HDH and St. Michael's Hospital, Toronto, became the first training programs in Canada for qualified medical record librarians.

One of the first courses was "kind of trial and error those first years," according to 1938 graduate Eileen Carty Hartnett.

The instruction in the class included anatomy and medical terminology, the most important part of the course. The course was about 10 months long, and provided practical experience in taking patients' histories. When the patients were discharged the charts and all the attached information came down to the records office to be filed. "Sister's office was in the Sydenham wing, the old wing. Most of the records were kept in that one room, and we had classes in that one room. We had those great big charts for each patient, volumes of paper."

By 1942, the Association was renamed the Canadian Association of Medical Record Librarians. A Dominion charter was granted by Ottawa on August 24, 1949. The Association's regulations and curricula transformed dingy basement filing rooms into modern well-equipped departments. The curricula of the first schools were very basic, but with increased medical sophistication, these curricula expanded to include ethics, psychology, anatomy and physiology.

Sister Kathleen Keevil succeeded Sister Marie Gordon as Chief Record Librarian, and shortly thereafter the School was named the Sister Campion School for Medical Record Librarians, to honour its first Director.

During Sister Keevil's term, between two and four students a year entered the one-year program. They were responsible for their own room and board, but could obtain an Ontario tuition bursary. Classes in anatomy were taken in conjunction with the nurses' training program. After six months' training, including classes regarding medical records and jurisdiction, students would begin to deal with actual records, some doing field work at KGH and other hospitals. Sister Keevil is very proud that for two years in a row, students from HDH won first-class honours. As far as she knows, there were never any male students at the School. "I guess it was a woman's world at that time," she said.

Sister Keevil served as Director from 1960 until the School closed in 1974, on September 28, after 40 years of Medical Record Librarian education, at the same time the other HDH schools closed. Although the training given at the other schools moved to St. Lawrence College, the Medical Record Librarian training in Kingston came to an end.

Since the School closed, great changes have taken place in medical records. Electronic files which retrieved the needed record at the push of a button saved much back-breaking

bending and stooping. Later, a computer-based Hospital information system was introduced, and data are now retrieved electronically.

SCHOOL OF RADIOGRAPHY

As x-ray machines became an integral part of medical investigation, technicians had to be trained to operate them. At first, students received on-the-job training, and the first record at HDH lists one student x-ray technician in 1953. In 1957 the HDH School of Radiography officially opened with a registration of five. It provided a two-year on-the-job training program under Dr. Ronald Burr and Mrs. Olive Cass. By 1959, enrolment was six, and in 1960 four.

On February 6, 1960 the first public Radiological Graduation exercises for the Eastern Section of the Society of Radiographers was held in the Jeanne Mance Residence, with three HDH radiographers among the graduates. Two years later, joint graduation exercises were held again, including two HDH graduates. By 1970 the School had 16 students, with three resident radiologists handling the training program.

Today, the School of Radiography is the only School still in operation at HDH, and held its 37th graduation ceremony in September 1994. It is now affiliated with schools at five other hospitals: St. Vincent de Paul in Brockville, HDH Cornwall, KGH, Pembroke General Hospital and Belleville General Hospital, all participating in the training program of the Eastern Ontario School of X-ray Technology.

The two-year program includes both practical experience and didactic training. All students spend 15 months at their own hospital in the clinical practice portion, which is broken into semesters and interspersed with classroom instruction. The didactic training is held at KGH, where the 23 students from all the hospitals attend classes in physics, ethics, nursing care, anatomy, physiology, radiobiology, image recording, radiography and radiographic apparatus.

The HDH School, according to clinical instructor Charleen Power, accepts five students each year into the program. Traditionally, there are more female than male students, and women still outnumber men. At September 1994 three male and seven female students were enrolled at HDH.

CLOSE TO HOME - KINGSTON'S NEEDY

From the beginning, the RHSJ have cared for the poor and needy, as well as the sick. A multitude of unrecorded acts of charity over their 150 years in Kingston helped those unable to help themselves. From the sick in La Flèche in 1636 and cholera victims in Kingston in 1845 to the poor, hungry and lonely today, the Religious Hospitallers of St. Joseph continue to serve the sick, the poor and those in need.

Although much is undocumented, some more recent outreach efforts were chronicled. In February 1967 a clothing exchange was set up in the basement of the Johnson Street wing, with Mr. Frank Hall, an hourly employee, in charge. The program was taken over by other agencies in the city when the Hospital needed the space.

Three times the Sisters have helped to establish shelters. The first was one they themselves operated. For a period in the early 1970s, the Social Services department, with the help of the Ladies Auxiliary, operated the former Canadian Register Building as a youth hostel. In 1985, the Sisters, along with the Sisters of Providence of St. Vincent de Paul and the Congregation of Notre Dame, established Dawn House, a shelter for homeless women and children, for women temporarily unable to afford a residence for themselves and their families, and who are helped to resettle. The third initiative helped by the Sisters is the entirely independent Almost Home, a community hostel where parents of children in HDH or KGH can stay. Paediatric staff work closely with their staff, and it is almost part of the Hospital although quite independent and run by a separate Board.

Individual Sisters and members of the Hospital community have also undertaken outreach programs. One Sister, a retired teacher resident in the Provincial House in Amherstview, continues to help students with reading and mathematics, and one member of the housekeeping staff with English lessons. Other Sisters are involved with local outreach programs.

Dr. Brian Wherrett and others in the department of Paediatrics have been involved with a research initiative to aboriginal Canadian children in the Tyendinaga Indian Reserve. They provide a consultation service, help assess the needs of

children at the Quinte Mohawk Primary School with learning disabilities and developmental problems, and support the special education program. Paediatrics also holds clinics at the Quinte Mohawk School and Belleville General Hospital, and a tropical diseases and sexually-transmitted diseases clinic at the Kingston, Frontenac, Lennox and Addington Health Unit.

As part of Family Medicine's focus on the Kingston community, the department also helped with the development of the North Kingston Community Health Centre. It provides some services at the Prison for Women and at the Rideau Regional Centre in Smiths Falls, where the departments of Ophthalmology, Orthopaedics and Otolaryngology also hold regular clinics.

Because the number of Sisters is shrinking and the laity are needed to fill some of the positions in the healing mission of the church, the Pastoral Care department, as detailed earlier, is now training people from across the Archdiocese to meet community needs and encourage wellness.

Dial 911 for Emergency

Photo by Jennifer Shea

Ambulance officers Mark Schjerning (L) and Randy Fowler (R) demonstrate advanced life support (ALS) techniques on a mannequin.

On April 2, 1930 45-year-old Stuart Murphy from Wolfe Island was the first patient to arrive by airplane. Because of the treacherous ice, he had been unable to reach Kingston with a severe appendix attack. He was flown to Kingston airport and rushed by ambulance to the Hospital. Unfortunately his appendix had ruptured a few hours earlier, and he died on April 5, leaving a young wife and nine children.

Before the advent of the 911 and Kingston Regional Ambulance Service, if people required emergency assistance they had to telephone the police, the fire department or the ambulance directly. Ontario's ambulances were uncoordinated until in 1966 a Task Force was set up to plan a comprehensive service across Ontario. The following year, the new Emergency Health Service placed ambulance service on a 24-hour basis and developed training programs for ambulance attendants, emergency medical volunteer groups and Hospital staff. Finally, with the Ambulance Act of 1968, the Ontario Hospital Services Commission received the authority to administer all ambulance services, public and private; and the Kingston Regional Emergency Services began operation at HDH on September 11, 1968, earning its place in history as the first ambulance service established in Ontario under the Ambulance Act. It operated out of one room at HDH with a staff of 13 full-time officers which included medical students and Armed Forces medical personnel. That year about 8,000 calls for help were answered.

"At first we had four yearly courses on advanced life support for ambulance personnel," said Dr. William R. Ghent, who organized the Automotive Crash Institute in 1967, the first of its kind in Canada, to investigate the causes of traffic accidents. "They were given advanced cardiorespiratory training, training in tracheotomy, and in chest tubes. In all there were about 40 graduates." KGH provided experience in obstetrics and the HDH School of Medical Technology gave a short informational introduction to bacteriology. "What we were teaching then is now the basis for the advanced life training support techniques used throughout the United States," said Dr. Ghent. Dr. Ghent was considered one of Canada's foremost experts in traffic accidents, and promoted seatbelt use long before it became mandatory. He was also influential in toughening highway safety laws. In 1969 he was named Kingston's Citizen of the Year for establishing Kingston's first hospital-based ambulance service. He also

advocated the use of helmets for drivers, special panic training, and repeated viewing of full-colour highway crash scenes.

Shortly thereafter, provincial government funding for the training programs was cancelled. "Now," he said, "the ambulance service is a transport service. It carries people from place A to place B. To get the further political brownie points we now have helicopters to do it in style." Ambulance drivers are permitted to give cardiopulmonary resuscitation, but they cannot insert tracheotomy tubes and until recently could not use "paddles" to restart the heart.

Dr. Ghent recalled reading one complaint that vividly depicts some of the problems of ambulance service in remote areas.

"There's a complaint from Central Ambulance Service to the Madoc detachment of the Ambulance Service of why it took them from 12:30 noontime on Thursday till 3 a.m. on Friday to get this American tourist with a fractured leg to Hospital. The dispatcher's letter back is an absolute gem. First of all they found the patient at the end of an hour, at the end of a five mile road that they had to back into because it was so narrow; and then they found him across the lake and there was no bridge or anything around the lake. They had to build a ramp and float him across and get him in the ambulance and then subsequently all the way out it was detailed. He ends up by saying, 'I returned to base at 3:13 a.m. on such and such a date.'"

In January 1981, the Emergency Health Services Group was established by the Ministry of Health to focus planning, development, coordination and management of all emergency health services in the province. Today, ambulance drivers attend a two-year course in Emergency Medical Care Attendant Training at community colleges.

The Ambulance Service later moved to the Jeanne Mance Residence, and in the late 1970s to 412 Bagot Street, now the site of the Partners in Mission Food Bank. Its current home, acquired in 1988, is 250 Palace Road, known as Station Zero-Base. The five-bay operation houses three ambulances, the emergency response/administrative vehicle, the emergency support unit, and as headquarters housing the administrative offices. The "Base Hospital," now called "The Centre for Emergency Health Services, Southeastern Ontario," which coordinates the planning, education and quality assurance programs for all the ambulance services in the area is located at HDH. In

November 1986 the Kingston West Ambulance Base, Station Zero-One, officially opened on Bath Road at Collins Bay in Kingston Township, to meet the needs of a population expanding rapidly to the west. With one vehicle staffed 24 hours per day, and a spare vehicle, the Station serves the northern and eastern rural regions of the catchment area as well as the north end of Kingston. On October 18, 1991, a new ambulance base was opened at the intersection of Highway 15 and Highway 401 in Pittsburgh Township, Station Zero-Two. By 1991 an Associate Base Hospital program, an outreach program of the Centre for Emergency Health Services, was instituted. Brockville, Belleville, Smiths Falls and Perth are potential future sites providing more effective pre-hospital care throughout the region and improved liaison between the centres and the Centre.

The Ambulance Service serves a 1,400 square kilometer area from Amherst Island, Bath, Odessa, Yarker, Moscow, Hartington, Gould Lake, Bedford Mills, Battersea, Joyceville, Pitts Ferry to Howe Island.

In 1987-88 HDH was named one of 10 training headquarters in Ontario for the new Centre for Emergency Health Services Program, responsible for paramedic training, pre-hospital care, research and consulting on emergency issues such as the 911 telephone number, coordinating educational sessions and assuming responsibility for the critical-care transport operation.

In 1990 the Board of Directors approved the Air Ambulance Service providing fast transportation to Kingston and Ottawa hospitals for critically-ill patients through the region. The helicopter is involved only in the transport of acute-care patients or in the transfers of patients. Crews are ambulance officers with upgraded skills so that patients do not have to be accompanied by hospital or institutional staff.

In October 1990 the 911 service in the Kingston area was instituted, mainly through public pressure on community and provincial governments. It was becoming unsafe not to have 911, because so many believed from television it already existed everywhere.

HDH then proposed a Critical Care Hotline program for rapid, safe transfer of critically-ill patients to the appropriate tertiary-care facility. Physicians lacked information about availability of critical-care beds, and had limited access to medical consultants. Transport teams also needed better coordination. In

the plan, now implemented, a telephone number links the referring physician to a trained referral coordinator in the Admitting Department. The hotline links referring physicians to all the acute care medical services in the Kingston Health Sciences Centre. The Centre for Emergency Health Services provides medical direction, quality assurance and program evaluation, and the Admitting Department supervises the operational and technical functions of the program.

The Kingston Regional Ambulance Service now employs 28 full-time and 17-part time officers plus managerial staff, and handles an average of 16,000 calls each year, about half of them emergency calls. HDH and KGH now receive patients transported by helicopter to a helipad on the waterfront between the Queen's University heating plant and the KGH parking area. The pad, built at a cost of $113,598, was completed on November 29, 1993. It was officially dedicated and blessed on October 7, 1994 and nicknamed Visser's Landing in honour of Arthur Visser of Cardinal who was born on it on January 20, 1994. More than 90 percent of the patients transported either have trauma injuries or are obstetrical cases, and a site near KGH was desirable. By the end of 1993, Kingston was receiving an airlifted patient on average every second day.

The main barriers to fast transport in the Kingston area are not so much highway congestion, as causeways, waterways and ferries. As well, transporting a critically ill patient from a smaller community to Kingston often deprives it of its ambulance service and emergency department physician for a significant period of time. That time can be cut considerably using air ambulance, although helicopter travel does entail some risk.

Enhancements to the 911 services will soon contain technology to track and lock calls on the caller's location. The ambulance dispatching service psychologically supports the caller and provides directions in very specific well-thought-out instructions for emergency care.

In 1994 the Service celebrated its 25th anniversary, just in time to hear the Ministry of Health announcement in August that Kingston would be one of 21 communities involved in a $750,000 study. Local ambulance drivers will soon be able to offer full paramedic skills in emergency situations, including performing tracheotomies, starting IV treatment, treating severe allergic reactions and drug overdoses, and helping those suffering from respiratory failures.

The Service will also enlist firefighter support over the large region in the hope of doubling the number of cardiac arrest patients saved each year. Three hundred local firefighters will be trained in using defibrillators, which cost $8,000 to $10,000 each. Kingston must demonstrate that it can meet the required response time of less than eight minutes by July 1995. Then the ambulance drivers will be eligible to enter the 16-week paramedic training program. Already four of Kingston's ambulance drivers have learned paramedic skills during their off-duty hours; and two, Mark Schjerning and Ross Brown, took first-place honours at the National Advanced Life Support Competition in Winnipeg on the weekend of May 1, 1994, defeating all the other teams, who already use their skills daily.

Hotel Dieu Detoxification Centre

Following an announcement in August 1979 by the Minister of Health Dennis Timbrell of funds available for a Detox Centre at HDH, on September 21 the first meeting was held about establishing such a Centre in Kingston. Sisters Kathleen Keevil (who chaired the steering committee) and Loretta Gaffney (a committee member) visited St. Catharines to see the Detox Centre there, in operation since 1975.

Early in 1980 an announcement was made that 202 Johnson Street had been purchased as the site. The Sydenham Ratepayers Association objected immediately, and by March 15, it was still "in ferment". On March 20, a special Detox workshop was held in HDH auditorium to present the history of detoxification in Ontario, a description of the St. Catharines Detoxification Centre, and the medical perspective and research view of the innovative aspect of the service. However, on May 4 court proceedings initiated by a neighbour blocked the Centre. The Sisters decided to keep the idea "in wraps" until a suitable site was found, noting that the problems were reminiscent of the 1841-45 time needed to start the original HDH.

By December 1, 1981, HDH was negotiating for a new detox centre site. City Council was asked to remove an archaic clause in the zoning by-law that prohibited the treatment of inebriates — who had actually been cared for at HDH since 1845. Finally, on May 27, 1983 the first client was admitted to the Hotel Dieu Detoxification Centre at 240 Brock Street, although the official opening was not held until June 3. This became the 16th fully-established detoxification centre in Ontario, providing

12 male and three female beds in this much-needed facility. For a brief period during the 1985-86 winter, it was found that the Centre operated at 70 percent occupancy, leaving up to six beds empty per night. Because of the community need for crisis housing, from February to April 1986 the facility provided emergency shelter for the homeless.

After further renovation, the Detoxification Centre officially reopened on May 25, 1990. It now offers a total of 24 beds, separate facilities for women, wheelchair access, a self-contained suite for a single parent and child, a staff room, treatment room, counselling offices, and a meeting room.

Partners in Mission

Unfortunately, many of those in the Order have now reached retirement age. "We wanted to find out if there were other ways in which we could carry out our Charism and still remain active according to our mission and philosophy," said Sister Evelyn Leonard, first director of the Partners in Mission Food Bank. In the mid-1980s, with the help of the professional consultants David Ruhmkorff and Company, the Sisters conducted a survey of parishes and various social agencies to determine just who most needed help in Kingston and Amherstview: "the lonely, the homeless, substance abuse, hunger," said Sister Leonard. "We looked at those needs and we felt that maybe hunger was one of the ways that we could probably help because our Charism is service to the poor and the needy." In the Kingston area, 6,000 people were going to bed hungry every night.

Following their long tradition of collaboration with lay persons such as Jérôme Le Royer, Jeanne Mance and Josephine Perras, the Sisters invited individuals and groups to be their "Partners in Mission" in the Frontenac and Lennox and Addington counties identified in the survey. On June 17, 1984 a food collection began at four city parishes — Holy Family, Good Thief, Blessed Sacrament and St. Linus — passing out white plastic bags with "Partners in Mission" printed on them on one Sunday, and collecting them the following Sunday with whatever the parishioners could afford to give. A temporary food bank was set up at the Provincial House in Amherstview.

On November 6, 1985, the feast day of the Founder of the Order, the Sisters opened a second food bank in the Anglican Church of the Redeemer in Kingston. "Immediately we started

getting donations of needed equipment, and people were volunteering to help us," said Sister Leonard.

To be eligible to receive a food basket containing a one week supply once a month, families or individuals were referred by either a local social agency or a responsible individual.

Soon, other churches joined in the effort. "To date," says Sister Leonard, "we have over 100 churches that are assisting us in one way or another." By 1986, close to 17,000 items of food and about $4,500 were collected in the first food blitz, and Sister Leonard was named Citizen of the Year by the Kingston Chamber of Commerce. Food blitzes by HDH employees are held every year.

The Church of the Redeemer soon proved too small to house the Food Bank. In 1989 the "Partners in Mission Food Bank" opened in a 4,000 square foot warehouse at 412 Bagot Street in the city of Kingston. Although truly ecumenical with members of churches of all denominations throughout the city collecting food, it continues to be sponsored by the RHSJ. The new quarters provided office space for the coordinator, an office for computerized client information, a small kitchen and rest area for staff and volunteers, shelving and sorting space for donations, and a storage area for supplies.

Donations have included vans and a station wagon. Today, two station wagons pick up donations from local stores — bread, muffins, buns — and deliver baskets to those unable to come to the Food Bank. About six to eight such deliveries are made a day. Those picking up their donations, 40 or so a day, show identification and sign for the food received. "This is to protect the food that has been given to us to manage. We want to be good stewards. We also receive very substantial financial donations from all walks of life. We've really been overwhelmed by the generosity of the people of the city of Kingston," says Sister Leonard.

In 1992 8,050 food baskets with an approximate value of $500,000 were given to almost 700 households representing about 2,200 men, women and children. The Food Bank also supplies food to some agency-operated feeding programs such as the St. George's Lunch Program. In 1993, records were again broken, with about 900 requests per month for food, and 1,023 in August.

All bread is donated. Milk, eggs, meat, margarine and other staples such as peanut butter are bought using donated

funds, and on occasion some fresh meat is donated. Today, five full-time staff are employed at the Food Bank: a coordinator, an office manager, a computer-input clerk, a driver, and a warehouse manager. Almost 100 volunteers help at Bagot on Monday to Friday, and in Amherstview three afternoons a week.

In addition to the major food drive in the Greater Kingston Area at the end of May, additional unofficial drives take place around Christmas time. "Generosity comes to life," says Sister Leonard thankfully.

Other groups have provided help regularly. The Kingston Horticultural Society urges local gardeners to plant an extra row of vegetables, and market produce vendors donate what is left at the end of market day. In 1990, the annual Key Showcase craft show of the Correctional Service of Canada began to invite the Food Bank as guests, to accept donated food and sell raffle tickets. Food from the prison farm, Pittsburgh Institution, has also been sent to the Food Bank. On December 11, 1991 an outdoor festival of bonfires and carol singing was held at Fort Henry - admission was a donation to the Food Bank. On December 13, 1992 the Telephone Pioneers presented the Food Bank with a much-needed van. Other donations have included refrigerators and freezers. Local schools, church groups, Queen's University students and faculties and other organizations in the community also help, including Guides and Brownies who assist in making up the food baskets. More than 80 churches collect food on a regular basis each month.

By the end of 1992, about 163,000 people had been helped. "You hate to think it's necessary to have a food bank, but it certainly has done a lot of good, not only in feeding the hungry but helping the churches to work together and giving people who want to help the poor a way to go about doing it," says Sister Leonard.

However, this was not the first time that the Sisters had fed Kingston's hungry. In 1930, at the height of the depression, about 370 arrived at the door of HDH in want, and were fed.

Nutritionist Mary McLean remembers that in the 1950s "we always had bags of lunches ready, a package of sandwiches and maybe an apple and some cookies, because there were poor people coming to Emergency all the time when it was on Brock Street. All of the hobos or wanderers were St. Joseph's, as they called them, and you had to look after them. I remember there was one lad who came right around to the kitchen. The

sandwich I think was bologna that night. He came around the door — and you could smell him a mile away, he'd probably just come over from the Royal [Tavern] — and said, 'I can't eat bologna. I've got an ulcer.' I said, 'Gee, I'm sorry. That's what we're serving today.'"

They were still coming to the Emergency Department in the 1960s for food as well as medicine. "Sister Rouble always made up sandwiches. Some nights there'd be lineups of people for the sandwiches. We'd call over to the kitchen, go get the sandwiches, and hand them out to the people who needed them. We called them 'bumwiches,'" said Emergency nurse Maureen Little.

OUTREACH TO THE NORTH

As described in Native Patient Services, since 1970 HDH and KGH have provided tertiary care, and St. Mary's of the Lake has offered support in chronic care, to the native population of James Bay. A number of specialized services are provided through the University connection by both Hospitals, the Medical School and the Queen's University School of Nursing: obstetrics and gynaecology, orthopaedics, ophthalmology, otolaryngology, urology, surgery, neurology, neurosurgery, nursing, internal medicine and rehabilitation. As well, the Paediatrics department holds a clinic in general paediatrics, paediatric cardiology, rehabilitation and developmental services, and paediatric orthopaedics.

A task force was formed in 1983 to coordinate transportation, admission and education, translation services, patient support and education, and accommodation for patients and visiting families. It was also intended to ensure cultural sensitivity to the Cree and Inuit patients. In February 1985 funding was received from the Department of Employment and Immigration to support a Native Patient and Family Support Services project. In the first six weeks of the project, 37 native patients were admitted to Kingston hospitals, seven above the monthly average. Of those admitted, 37 percent needed translation services in Cree or Inuktitut. More details of this outreach program are supplied in the "Patient Care" segment of the book.

Geaganano Residence

The house at 176 Johnson, formerly occupied by Dr. F.D. O'Connor (deceased), then used as the interns' residence and later as Emergency Department offices, was affected by a zoning change which meant it could no longer be used as office space for the Hospital. At the same time, numbers of Cree patients and their families were now arriving from the north. HDH entered into a contract with Moose Factory General Hospital to provide accommodation. In September 1985 the house, an integral part of the Native Services Department, was officially dedicated as the Geaganano Residence, Cree for "a home for all of us." The 12-bedroom residence provides a hostel-like setting for accompanying relatives of paediatric in- and outpatients from the James Bay area, with every effort being made to reflect Cree and Inuit culture. A Cree-speaking house parent lives in the house. The relief house parent and the housekeeper also speak Cree. For a brief period, the Residence also served as "home" for Afghani refugees being treated at HDH.

Courtesy of Native Patient Services, Hotel Dieu Hospital

Moose Factory, Ontario.

OUTREACH TO THE WORLD

Following the Second World War, the Hospital helped house a number of displaced persons from Yugoslavia and Poland. Many found temporary work in Nutrition Services. On December 19, 1956, the former Nurses' Residence was converted to a home for 27 Hungarian refugees, some also employed by Nutrition Services. Refugees continued to concern the Sisters, and in 1980, a family from Vietnam was sponsored.

In 1987, Hotel Dieu became the pilot hospital in Canada in special care to refugees from Afghanistan. To care for the many war wounded the Afghan Medical Relief Organization was formed in 1985, with Dr. Simon Wren of HDH as Chair of the Medical Subcommittee. HDH's Board of Directors agreed to provide free the restorative surgery not available in Pakistan to Afghani victims.

Already living in Kingston was Prince Mohammad Mostapha, grandson of the deposed king and a student attending Queen's. Before the first Afghani patients arrived, with the Prince's help staff members took part in an orientation program to discuss religious, dietary, language and cultural differences. As the Prince pointed out, "Try to imagine they will arrive in a time machine travelling from the eleventh century to the twentieth."

Sharafudin, 14 years old, and Ahmadzai, 18, arrived in February 1987. Sharafudin had been hit by a three-inch piece of shrapnel in his right leg. The shattered femur had been set poorly, making the leg shorter and requiring a crutch. It had also been infected for 15 months. At HDH his right knee was fused and a piece of bone inserted to lengthen the leg. Four months later he left for Pakistan.

Ahmadzai's left leg had been fractured by a bullet, and in spite of three separate attempts to stabilize the fracture, he required further treatment to combat infection. He had also developed a hearing loss due to the combination of massive doses of antibiotics and the noise of shelling and gunfire. A privately-donated hearing aid rectified the problem. Ahmadzai could read and write Pushtu, one of the 11 distinct Afghani languages, and helped Child Life worker Bill Frid put together a handbook of diagrams with descriptions in Pushtu and phonetic English.

A third patient, 12-year-old Buswaliha, arrived in March with an infected gunshot wound in her right ankle, and a left

arm partly amputated by doctors in Peshawar, where she had been carried 60 kilometers by her brother on his back. She received surgery to her ankle, and a new artificial arm.

In 1987-88 a five-year-old with a severely deformed right leg, badly set after a bomb hit his home, buried him under rubble and broke the leg, became the ninth Afghani child to arrive, and the youngest treated.

Food presented cultural and religious challenges. The children had never seen prepackaged food. Faith and prayer are very important to these Muslim children, and great care was taken not to disturb them when at prayer. Women in Afghan society have a role far different from those in North America, and Sharafudin remarked one day, "Some of the nurses were shameless but very nice." Another child commented, "I was amazed that the nurses were so friendly and warm. It didn't seem I was thousands of miles away from home."

A number of the paediatric staff are interested in international health. Two Russian children, actually young adults, have been treated at HDH, thanks to the Ronald McDonald Foundation. One, 12-year-old Samira Zeynalova, was a polio victim; and the other suffered from major congenital defects. Both had major rehabilitation needs.

The Paediatrics division also supports an outreach consultation program in Guyana, Malaysia, Africa and Asia, part of a Queen's network of chronic-care groups. The department encourages this type of activity among its staff, seeing it as very much within the philosophy of the Sisters.

THE LADIES AUXILIARY - "From words to loving action"

The first "Ladies Auxiliary" associated with any Hotel Dieu Hospital had three members. Among those members, serving the Hotel Dieu at La Flèche, was Marie de la Ferre who became the foundress of the Order of Religious Hospitallers of St. Joseph.

Long before the establishment of the Ladies Auxiliary of HDH, the second oldest Roman Catholic women's organization in the city, volunteers helped the Sisters. The first volunteer in Kingston was Josephine Perras, while Mr. Laframboise sent supplies of provisions for the Sisters and the sick. As detailed in the history of those early days, others also gave gifts of food, furnishings and funds. In 1849 Mrs. Alexander Cicolari of Kingston provided a Turkish carpet for the sanctuary in the Chapel, a pair of snuffers, and a silvered stand. Mrs. Ellen Hickey donated a mohair-bottomed chair. Mrs. Belanger (who had attended the first Mass along with other townspeople) gave six carved candlesticks.

Bequests supplied much-needed funds, such as $900 from Mrs. Kennedy of Belleville, and $2,000 from Squire Patrick McMullen of Erinsville, a relative of Dr. William Gibson. Lotteries and bazaars also helped finance the Hospital. One 1861 bazaar raised $1,800, and a second $1,600. In 1869 Dr. Sullivan donated a silver dish as a lottery prize. Mrs. Sessions, aunt of the Sister Superior Jane Leahy, gave two ponies for a lottery which brought in $500. In 1872, a concert organized by the ladies of the town for orphans raised $335.

The Ladies Auxiliary of Hotel Dieu Hospital itself began on Wednesday, June 28, 1905, when Reverend Mother de la Dauversière, her Council of Sisters, and 105 women of the city met for the first time in the orphanage on what is now Sydenham 5. The original objectives of the Auxiliary were to extend the interests of HDH to all parts of the city and surrounding counties; to solicit and receive donations; and to assist in erecting, furnishing and maintaining the Hospital. Mrs. Mary Browne Sullivan, wife of Dr. Michael Sullivan, was the first honorary president, and supported the Auxiliary until her death in 1924.

Under the first president Mary Ellen Fahey Welch (a graduate of Notre Dame Convent) during that first official year the ladies of the Auxiliary set the pattern for years of service. They raised $1,042 with a lawn social, held rummage sales, linen showers and garden parties, charged admission for "at homes" and "tea parties" in members' homes, and sold fancy work, candy and home baking.

Much of the funds raised over the years provided patient comforts, blankets, warm winter gowns, slippers and anything else needed for the poorer patients. Some members visited the sick weekly, and others sewed hospital linen, obtaining some donated materials from merchants and linen showers and purchasing the remainder from Auxiliary funds. In 1915 they bought a new sewing machine as well as bathrobe and nightshirt material. Over the years, Auxiliary members also made private donations of bandages, fruit, wine, air pads and hot-water bottles when they visited the sick.

Fund-raising was on-going, and developed a "high tech" slant with the 1909 purchase of a microscope for $65. Four years later, the Auxiliary contributed funds for a new operating room table and another microscope, and by 1915, had raised enough funds to purchase the first x-ray machine for the Hospital.

The first flag day in 1916 raised $1,408.88. In 1917, a military doll lottery was held, and the flag day on July 7, 1917 using Sweet Peas as "flags," raised nearly $1,300. At the annual linen shower and euchre party on November 21, friends donated linen worth $219.75, while cash gifts and proceeds from the euchre table, candy, cake, etc., amounted to nearly $500. The flag day on June 29, 1918 was transformed into a flower day, with $1,200 being raised. On March 19, 1919, proceeds from a linen shower amounted to about $2,000, and on March 20 the Chinese population gave $200.

From 1917 to 1967, a St. Patrick's Day Tea and Sale was held yearly by the Auxiliary. Mrs. Margaret Keenan, president at that time, also introduced St. Patrick's Day plays. These were put on in the Grand Opera House by Queen's University students and members of the Newman Club. Records state that "considerable sums of money were raised." Money-raising events continued over the years to help fund the Auxiliary's many activities.

The Auxiliary also took a special interest in the nurses being trained at St. Joseph's School of Nursing, and made the first donation towards the new nurses' home.

Mrs. Fergus J. O'Connor Sr. (Frances) then assumed the presidential reins, for two terms. She was the third Notre Dame Convent graduate to serve as president, and had a very strong Hotel Dieu connection, as outlined elsewhere in the book. Sister Theresa Farrell, Superior and HDH administrator for many years, was a close relative of the O'Connor family.

The usual garden parties, tag days and dances helped raise funds for the Auxiliary, and in 1922, a week-long mammoth bazaar held in City hall netted over $12,000. However, card parties became the main means to raise funds. Tables were made from bits and pieces of pine by Charles O'Connor and his cousin Bernard McNamee. A record tag day in 1936 helped celebrate the 300th year of the Religious Hospitallers of St. Joseph.

As the depression ended, the sick could once again afford the services of private duty nurses, and the Auxiliary made a sizeable contribution to maintenance costs for the Central Nurses' Registry.

In 1939, when World War II broke out, the Knights of Columbus of Kingston asked the Auxiliary for its cooperation in their drive for help for the army huts in Barriefield. Many social events were held in St. Joseph's Hall. Twelve dozen cups, saucers and plates were purchased for use at communion breakfasts and other events. The ladies provided mounds of sandwiches for soldiers' entertainments, some held in St. Mary's Hall by the Auxiliary. In return for their help with the soldiers, the Knights of Columbus donated a substantial cheque to help the Auxiliary acquire the first blood bank for HDH, at a cost of $600. Eight hundred invitations were issued to the 1942 St. Patrick's Day Tea and Sale, and when the Hospital Chapel was redecorated in 1944, the Auxiliary replaced the pews installed in 1895 with new ones, still in use in 1980. When the RCAF hospital in Trenton opened during the war, HDH gave a set of surgical instruments, and the Auxiliary was invited, with the Sisters, to visit the RCAF Training Centre.

President Mme. Charles Chabot (Denise) and the Auxiliary helped celebrate the Hotel Dieu Centennial in 1945, presenting Sister Breault with a large cheque to be used for the proposed Centenary wing. Other donations that year included an up-to-date incubator for Obstetrics, a resuscitator, and a fully

equipped blood bank at a cost of $1,000; and the Auxiliary also furnished many of the private rooms in the Hospital's new wing. In recognition of their efforts, Archbishop J.A. O'Sullivan addressed the Auxiliary at its annual meeting, the first time this honour had been conferred on the group.

Once again an O'Connor took over the presidential role, this time Mrs. Fergus J. O'Connor Jr. (Constance 'Connie' Davidson). While she was president, the Auxiliary extended its interests outside Kingston to the Province, and in 1947 was represented for the first time at the Ontario Hospital Association Convention in Toronto.

In 1947, St. Joseph's Hall was very busy with many bridge and euchre parties. 100 new chairs were purchased, and twenty-five new card tables to replace those made by Charles O'Connor in the Auxiliary's early days. The St. Patrick's Day Tea and Sale was a great success, and the Auxiliary's funds for patient comforts grew to $3,134.55.

On May 12, 1950, president Mrs. Clair Devlin (Helen Hurley) presided over the Open House held at the opening of the Centenary wing. Once again emphasis was placed on recruitment, and the Auxiliary began to reach outwards, extending invitations to non-Catholics to participate in its activities. The first name change, to Women's Auxiliary of Hotel Dieu, came in 1958. In 1963 junior volunteers, or "Jeannettes", were recruited from Notre Dame Convent and Regiopolis College. About 60 teenagers were thanked at a Christmas party which included "Martian Hopping." Dorothea Emond served as the Director of these "Candystripers" in 1963-64.

In 1950 the Superior, Sister Borden, asked the Auxiliary to raise the then staggering sum of $10,000 for a central cafeteria to replace several small dining rooms. By 1952 they had met this first major commitment, and the new cafeteria opened. The Auxiliary also purchased some major pieces of equipment: in 1950 a new deep therapy machine, and an artificial kidney machine for $2,000 in 1959.

During Christmas 1953, the Auxiliary activated a local campaign to put Christ back in Christmas, and members helped serve tea and welcome guests to the new Provincialate on May 8, 1957. On May 4, 1960, the Auxiliary hosted a tea for the six Sisters celebrating their Jubilee, many of whom had been among the postulants who had come from Ireland in 1907. A popular hat table, "Chapeau Daisy", was added to the St. Patrick's Day

Tea and Sale by Mrs. Daisy O'Leary, a milliner in her younger days.

Mrs. Harold Neuman (Jody Chown), the granddaughter of George Chown who once owned the Kingston Public library property on the corner of Bagot and Brock acquired in 1976, became the next president and the first unpaid volunteer "Director of Volunteers" in 1960-61.

By the early 1960s the Women's Auxiliary had fallen out of favour because of changing social times. The afternoon tea was no longer fashionable, the bazaar was no longer the major fundraising event, and with more women returning to the work force willing volunteer hands to produce arts and crafts were becoming fewer. A tiny volunteer canteen had opened on February 20, 1963, the first year clearing $527.41; and in 1964 a new gift and coffee shop opened in the Sydenham Street entrance. With business aspects of the Auxiliary expanding, in 1960 several members attended an Institute for Directors for Hospital Volunteers, held at Belleville General Hospital.

An antique flower planter from the Hillcroft home of Mrs. Harry Smith was put into service as the first Sunshine Cart on December 1, 1961 at a cost of $149. Volunteers manning the cart three days a week from 2 to 4 pm wore cherry-red smocks with an auxiliary chevrier to distinguish them. It is still one of the most successful volunteer services.

In the late 1960s the Auxiliary set up an orientation program for its volunteers — 32 were needed in the coffee shop, 24 for the gift shop, and 20 for the sunshine cart. To volunteer, it was not necessary to be an active Auxiliary member. A special memorial brochure about the Auxiliary was prepared, and a blitz brought in 56 volunteers. Today, volunteers still play a vital role in providing extra services.

When expansion plans for the Hospital in 1961 triggered a fundraising campaign, the Auxiliary pledged $12,500 over five years for the fund as well as helping in the campaign. The first Social Service department was set up, as were both surgical and medical intensive care units. All the new services requested help from the Auxiliary, which in spite of the building fund pledge met the requests.

In the early 1950s Mrs. Peggy Murphy made the first request that the President of the Ladies Auxiliary sit on the newly established Advisory Board, an event that would not come to pass for 20 more years. Once again, in 1958 the Auxiliary

tried unsuccessfully for representation on the Advisory Board, but was represented on a Committee set up to meet with the Planning and Development Committee of the Board. In 1964 the Hospital Board was restructured from the 1951 Constitution to allow larger community representation. The first female appointment from the Sisters to sit on the Board was Miss Mary Alice Murray, a Kingston lawyer, who spoke to the Auxiliary as Chairman of the Public Relations Committee on the important role they play in the successful operation of the Hospital. Finally, the Auxiliary won its case for Board representation. Lois Hazlett became the first President to serve on the Board in 1970-71.

A play therapy service in Paediatrics was set up in 1966, with the Auxiliary providing the needed play items. In 1967 the Auxiliary gave the Hospital a $10,000 cheque, and in 1968 $9,000 for otolaryngology equipment as well as providing patient comforts and purchasing hospital beds for orthopaedic patients. From 1966 to 1970, the major portion of Auxiliary revenue, $26,000 in all, was used to refurnish rooms in the older sections of the Hospital. The Auxiliary also took an active part in the Open House celebrating 125 years of service by the Sisters.

However, a long Auxiliary tradition came to an end. The St. Patrick's Day Tea and Sale, featured since the beginning of the Auxiliary, was discontinued. The Auditorium in the newly opened Johnson Street wing did not lend itself to a tea and sale; and the Jeanne Mance Residence, which contained 176 students, would be demolished within 10 years.

By 1970, at the end of its first 65 years, the Auxiliary's total financial contributions amounted to a staggering $145,000: $18,415 for nurses' prizes, scholarships and bursaries; and $126,585 for the Hospital itself — building fund, equipment, patient comforts and refurnishing. A plaque in the main lobby of the Hospital was installed to honour these efforts. The work of volunteers is remembered as well in the Sydenham Street rotunda by a scrolled remembrance of the women who had given long service to the Auxiliary, painted by Mrs. Susan Paloschi, a talented artist and wife of Dr. Gian Paloschi. The Auxiliary had also assumed the additional responsibility of providing such volunteer services as the Hospital administration required.

Lois Hazlett assumed the presidency in 1970. She learned of open visiting hours at the Sick Children's Hospital in Toronto, and suggested that HDH adopt the practice, a venture that allowed parents to help look after their children in hospital.

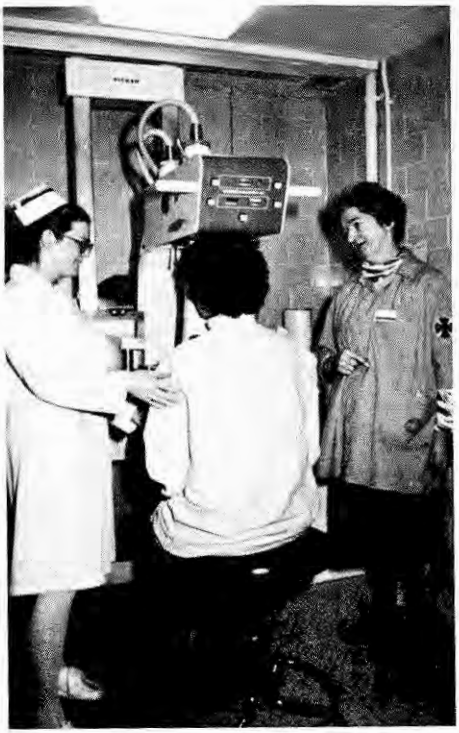
The Auxiliary also espoused pastoral visiting of the sick, and in 1971 furnished the Family Room in the area of the Interfaith Chapel (St. Roch's room). The third floor gallery became the Interfaith Chapel. Through Auxiliary efforts both rooms were decorated.

In 1972 Mrs. Marilyn (Jones) Braden, a nursing graduate of 1957, took over the presidency. She presided at two Tercentenary events, celebrating the 300th anniversary of Kingston's founding by Frontenac, which occurred a few days after Jeanne Mance's death, also being marked. As their Tercentenary project, the Auxiliary produced a tour map of Kingston that commented on interesting homes and historical sites in the city. On Hospital Day 1973 a special Jeanne Mance pamphlet was placed on each patient's tray.

Increasing numbers of volunteers were needed to staff the new services. As well, as Hospital staffing became "thinner", more volunteers in actual service areas were in demand. With the "volunteer" part of their activities becoming more important, in 1975 a new title was chosen: "Volunteer Services of Hotel Dieu," so that men could feel free to join, copying the example of that first male volunteer Mr. Laframboise who accompanied the Sisters in 1845. Members also hoped that the change would reflect the changing role of women in Canadian society, and would encourage women to volunteer as a self-fulfilling or useful activity when no longer needed at home full time. The organization is a branch of the provincial organization of the Ontario Hospital Auxiliaries Association.

On October 16, 1975, in honour of the International Women's Year, Volunteer Services pledged $30,000 for a mammography machine for the Radiology department to assist in early detection of breast cancer. It was also a fitting memorial for their 70th birthday.

Volunteer Services did not always agree with the direction taken by the Hospital administration. The group was unhappy about the transfer of obstetrics and gynaecology to KGH in April 1973, and about HDH providing care for penitentiary inmates. Many members objected, and in fact strikes by volunteers were threatened; but the philosophy of the Sisters states that <u>all</u> persons qualify for care. In 1976, the year of the Sailing Olympics in Kingston, Volunteer Services opposed the interim move of Paediatrics to KGH, part of the overall planning for the Health Sciences Complex.



Courtesy of Volunteer Services to Hotel Dieu Hospital

Mammography machine donated by Volunteer Services, 1975.

Volunteer Services persuaded the Hospital that a larger gift and coffee shop could bring in revenue more effectively, and so plans for the Jeanne Mance wing included such facilities in the main lobby. They also suggested that it be called the Jeanne Mance wing; and that the stone bas-relief depicting Jérôme Le Royer de la Dauversière blessing the departure of the Hospitallers from France to Ville Marie in 1659 be preserved when the Jeanne Mance Residence was demolished and be incorporated in the new wing. These wishes achieved reality, and the relief hangs in the lobby today.

In 1977, the group invested $18,000 so that funds would be available when the wing became operational, and presented the Hospital with a $32,000 cheque from the three money-raising Auxiliary services. Over the 75 years of its existence, from 1905 to 1980, Hotel Dieu volunteers had raised a total of $266,178.11 for the Hospital. As their pure business activities

increased, the number of volunteers also grew, as did their ability to raise funds.

In 1976, Volunteer Services also completed a unique handbook of English-Portuguese hospital phrases, written by Cordelia Dewhurst, assisted by Clarita Kade. One copy has been put on every ward, and has proven invaluable, since the Portuguese were the largest ethnic group in Kingston during the 1970s.

At a "Treasures Old and New" sale in September 1981, over $1,300 was raised, a start towards their pledge of $200,000 over five years towards the new Capital Appeal. In 1981-82 alone the gift shop and coffee shop contributed $73,000 to their funds, and the pledge to the appeal was achieved.

HDH hired its first paid volunteer coordinator, Linda Tucker, in 1988 to replace a long line of very capable unpaid volunteer directors. However, the changing role of women in the work place meant that many volunteers were no longer available. Today, HDH depends on paid part-time workers in the coffee shop, retirees and seniors to augment the volunteer framework.

In 1990 Volunteer Services made the first payment toward their $100,000 pledge for a second mammography machine, provided another $75,000 to the CAT Scanner campaign, gave more than $30,000 to purchase a variety of capital equipment, and another $30,000 to the Nutrition Services department to purchase a temperature control system for patients' food. They also funded renovations to the coffee shop, turned over $200,000 to the BEDS campaign in 1990-91, and donated their final $25,000 instalment to pay for the new mammography machine. In 1991 they pledged or donated almost $150,000. As well, 10,000 volunteer hours provided support to the staff of the Child Development Centre, the Children's Ambulatory Clinic and the Child Life Program.

Today, Volunteer Services operates sunshine carts, book carts, and coffee carts that distribute coffee, tea and juices free in the clinics. At one time a hairdresser's shop was located across the street, but with the sale of that building Volunteer Services felt it was much more efficient to have its own shop and opened the new salon, "Finishing Touch," on May 2, 1990. The shop can provide a mobile service to bedridden patients. As well as the good-sized coffee shop and the gift shop in the Jeanne Mance lobby, Volunteer Services also operates a booth, opened in 1992, selling lottery tickets, postage stamps, newspapers and

magazines and designating these funds for the purchase of capital equipment.

These varied small businesses now help Volunteer Services meet fundraising objectives by providing a net annual revenue of $40,000 to $45,000, almost seven times the mid-1960s revenue of about $7,000 a year. The funds will be needed. The organization has pledged $500,000 to the Healthcare 2000 campaign, specifically towards the development of Psychiatry at HDH.

In 1993 members of Volunteer Services, now numbering 322, contributed more than 30,000 hours of service as well as a cheque for $100,000, the first instalment on their Healthcare 2000 pledge. From 1905 to 1979, donations to the Hospital averaged $3,500 yearly. With the profits from its varied services, soon donations are expected to reach $20,000 per year; and by the end of its 90th year in 1995, Volunteer Services and its predecessors will have contributed almost $1.7 million.

Today, easily identifiable by their pink or gray smocks, they can be found in almost every area of the Hospital, helping with patient care and support services, and serving as hospital ambassadors.

There is a hard core of practicality to the operation of any hospital. It may offer tender loving care to its patients, as does HDH, but it also must oil the wheels of commerce with the grease of gold. Government grants do not meet all needs. Fundraising — and friendraising — are necessary for future growth and stability.

THE CENTENARY WING APPEAL

At the suggestion of Archbishop O'Sullivan to Mother Breault on January 8, 1945, a committee was formed to raise funds for a Jubilee wing in honour of the centennial. The wing, on Johnson Street, was intended to provide space for the Maternity and Paediatrics departments, and to improve to existing facilities. The Drive began in Kingston and Portsmouth on May 21. On September 11, 1945 Mr. William Casey, Chairman of the fundraising committee, presented the Superior with a cheque from the campaign. Including advance gifts obtained by the Archbishop of $55,000, and a $100,000 grant from the Ontario government, more than $300,000 was realized for the new Centenary wing.

THE JOHNSON WING APPEAL

In the early 1960s it was found necessary to raise $4,717,700 to build the Johnson wing. Needed at the time, according to Dr. John Hazlett, was some method of approaching corporations for the funds. Hugh Gibson and George Carson, active Board members, asked the Principal of Queen's University, Dr. Alex Corry, for a letter indicating the value of the Hospital in the teaching at Queen's University. Dr. Corry had just appointed a new Dean of Medicine, Dr. Harry Botterell, and was reluctant to write the letter without consultation with the Dean. Before Dr. Botterell officially assumed the Deanship, he travelled from Toronto to attend a medical staff meeting, at which time he outlined his plans to introduce clinical teaching units. It was as a result of that visit by Dr. Botterell that Dr. Corry subsequently did write the letter used in raising funds for the wing.

The goal for the public donation part of the campaign was $1 million. The campaign was very successful, with the doctors alone raising $165,000. The Sisters' gift was $500,000 from donated service funds, $82,700 from accumulated bequests, and a $1,222,000 mortgage payable over 25 years.

"IT'S UP TO US" - THE FIRST JOINT CAMPAIGN

October 1980 saw plans initiated for a joint fundraising campaign for HDH and KGH, the first time that two hospitals in Canada had ever collaborated on such a campaign. On March 3, 1981, the Honourable Justice W.J. Henderson, the chairman of the campaign, launched the joint appeal for $7.5 million. With the theme, "It's Up to Us," the campaign broke still more fundraising ground when an Ontario Municipal Board hearing allowed municipalities to make pledges beyond the mandate of those elected to the municipal governments. This permitted longer campaigns, and Hotel Dieu benefited considerably.

At the beginning of the campaign, the Mayor and City Councillors were given a tour of both hospitals. At HDH, the tour included the old operating rooms, where orthopaedic surgeon Dr. Don Taylor pointed out its flaws - its age and the lack of air conditioning. It becomes so hot, he told them, that the staff open a window; and one day while he was "doing" a knee, a pigeon flew in. Fortunately, the excellent infection control of the Hospital prevented contamination problems.

Although the campaign officially finished in 1982 and was a resounding success, since some counties made 15-year pledges funds are still coming in.

JEANNE MANCE FOUNDATION

The year 1981 saw the official establishment of the Jeanne Mance Foundation, under the joint management of a Board of Directors and RHSJ representatives. Its initial commitment was to assist in the acquisition of capital equipment for the new Jeanne Mance wing. It was established by the Board to meet future needs of the Hospital, and to ensure that the Hospital would not be asked to use donated funds as operating funds. One of its main functions is to manage funds generated by major appeals, in addition to any other direct contributions such as donations and bequests to the Foundation.

LE ROYER PATRONS

At the urging of Isabel Palda, the second woman Board Chair, the Le Royer Circle was formed in 1981, so that the many years of service of retired Board members would not go unrecognized and their experience and knowledge not be lost. It was named for Jérôme le Royer de la Dauversière, who as a lay person, fund raiser, and social and political activist serves as a role model for Patrons. The Board established the Circle as a Special Resources Committee of the Board of Directors, a standing committee. In 1985 the name was changed to Le Royer Patrons, members became known as Patrons, and involved other interested friends of the Hospital. Today there are about 125 patrons.

The Patrons include a substantial number of individuals with strong ties in the community who will have the opportunity through the Committee to turn their affection and admiration for HDH into real and significant support as ambassadors or friends of good will. They serve the Hospital in a number of ways. They may be appointed by the Sisters to serve on Board committees, act as consultants or assist with special projects, as well as supporting the Hospital in the community.

FRIENDS OF HOTEL DIEU

Until 1991 the fund-raising arm of the Hospital was the Jeanne Mance Foundation, its focus one of investment. However, it was realized that fund-raising activities should be linked directly to HDH for easy recognition by the community. A committee was formed by the Foundation, "Friends of Hotel Dieu", composed of patrons, trustees, RHSJ, Volunteer Services, and Nurses Alumnae. Members plan fund-raising goals and objectives in response to the Hospital's planning needs, and are involved heavily in the new Healthcare 2000 appeal.

PROJECT 140

The Hospital is always in need of bits and pieces of capital equipment. Governments provide operating funds, not funds for capital equipment. In 1985 Project 140 was inaugurated to raise $140,000 for capital equipment. (The RHSJ had arrived 140 years earlier.)

Fundraising in which the Sisters and the Kingston community were involved included a "Walk for Health," a Teddy Bear sale and a ball game. The target of $140,000, to be raised by 140 fund-raising projects, was exceeded when $181,000 was raised. The funds were used for surgical equipment to correct scoliosis, laser physiotherapy equipment, a paediatric ventilator, furniture for waiting rooms, urethroscope, surgical table, nuclear medicine work station, audiometer, tissue processor and a hearing device.

"THE" AUCTION

One of the events of Project 140 was the first annual auction, THE Auction, under Board Chair Isabel Palda. It raised $27,000 for Project 140. THE Auction has become almost an annual event, held every year thereafter until 1992. It was held again in 1993, but the 1994 Auction is being postponed until June 1995 to coincide with the 150th anniversary celebrations.

Funds from the auctions have been used to construct and equip an audiometric (sound) room for the department of Otolaryngology, purchase laser equipment for the surgical suite and a sigmoidoscope for gastroenterology, and assist the BEDS campaign.

THE CAT SCAN CAMPAIGN

In 1987, after about a year of preparation and after receiving Ministry of Health approval for the purchase of a CAT scanner for HDH, a $1.6 million campaign headed by Dr. John Milliken was launched. By April 15, 1988, departments in the Hospital were developing projects. One of the switchboard operators, Peggy Haggerty, wrote a murder-mystery play, performed one evening in March 1991 by an enthusiastic cast of HDH staff. By May 5, the fund had reached the half-way point, and by June 26, thanks to a TV telethon, the goal was within reach. Proceeds from the annual HDH auction, held on October 29, fattened the fund still further, and a local Chinese restaurant owner sent an $85,000 cheque to complete it. On January 20, 1989 the new CAT scanner was installed.

THE BEDS CAMPAIGN

On March 25, 1990 the Beds Campaign, chaired by former Mayor John Gerretsen, held its opening ceremony. The committee's goal was $800,000 to purchase 160 electric beds. Each room would contain an electric bed, new bedside furniture, and ergonomically-correct chairs. Volunteer Services committed more than $200,000, which helped achieve the goal.

HEALTHCARE 2000

On November 2, 1992, a joint five-year fundraising campaign for HDH, KGH and St. Mary's of the Lake was announced. The campaign has a $15 million goal, with HDH's share to be $5 million. The major part of the funds will be used to assist the department of Psychiatry to consolidate, the first time that a general hospital has raised money for psychiatry. Some will also help fund the HDH portion of the new geriatric assessment unit, the St. Mary's of the Lake part already in operation.

By the end of December 1994 more than $12 million in payments and pledges had been received. Although the active part of the campaign, during which the individual hospitals would not initiate any other major fundraising campaigns, was extended to the end of 1994, the hospitals are still hoping to achieve their $15 million goal.

The Lions Club donated over $9,000 to help fund the new gastrointestinal floor at HDH. "That was a project that a Lions member took on as a regional project, and it's now in and working. It is a part of Healthcare 2000 that we can already see the results of," said Thea Tidman, HDH's director of development.

OTHER CAMPAIGNS

Many businesses, volunteer groups and individuals have over the years contributed to the Hospital, and their assistance is vital. Capital equipment needs must be met by either setting aside funds from the increasingly limited operating funds provided, or by fundraising. Without these special fundraising events and the support of dedicated volunteers, much of the equipment would be lacking and some programs non-existent.

Children's Miracle Day

On December 15, 1987 Wood Gundy held its first Children's Miracle Day. Brokers donated the commissions earned that day across Canada to children's hospitals, and in Kingston the funds were dedicated to the Child Life Program. This now has become an annual event.

Festival of Trees

Under the guidance of Marie Shales, 1989 saw the first of what has become an annual Christmas event in Kingston, the Festival of Trees, a three-hospital unique fundraising event. Proceeds are divided among HDH, KGH and St. Mary's of the Lake. With the help of about 800 volunteers, that first Festival generated more than $90,000. The HDH share, $25,000, was placed in the Nursing Education Trust Fund. By 1991, HDH's share had become $40,000, $25,000 for the Nursing Education Fund, and the balance to the BEDS campaign. The 1992 Festival raised $40,000 for HDH, $25,000 for the Nursing Education Fund, and the balance for the Burn Unit. In 1993, the Festival pledged $275,000 over two years to Healthcare 2000. In 1993, it donated $140,000; and the 1994 amount may reach over $150,000.

Chili Fest

On October 5, 1991, a Chili Fest in Confederation Park with more than 50 participating Kingston restaurants raised $4,500 for the Burn Unit. It seemed appropriate - chili implies heat and burns. Disappointed at the results of that first Chili Fest, in 1992 the organizers again donated the proceeds, $7,800, to the Burn Unit. Since then, other charities in Kingston have benefited. But as Thea Tidman, points out, "Like THE Auction, it has become part of the social fabric of the community."

"OTHER CAMPAIGNS"

In 1988, the first **Annual Invitational Charity Golf Tournament** was organized by Dr. Walter Emrich, a local family physician. For the first couple of years the tournament was sponsored, but it is now self-supporting, and is so popular that advertising is no longer needed. Invitations are sent out, and by tournament time there is a waiting list. Proceeds were used to benefit paediatric patients and their families, purchase a blood

bank freezer, and help with the CAT scanner campaign. In 1991 $16,000 went to the BEDS campaign, in 1992 $17,622 to the Burn Unit. The 1994 proceeds of more than $10,000 are being dedicated to patient-controlled pain pumps for use in the Hospital. Over the years, the Annual Invitational has raised more than $100,000 for patient care equipment and other Hospital needs.

During the CAT scanner campaign, local entrepreneur John Belanger started an annual golf tournament, **The Belanger Golf Tournament**, which raises from $4,000 to $6,000 annually for Paediatrics.

In 1990, a group of employees organized an annual **Pat and Mike's Golf Tournament**. In 1992 over 90 HDH golfers took part, raising $1,000 for Healthcare 2000. The June 1994 tournament raised still another $1,000.

The **Kinsmen** donate funds to a special Paediatrics program, the Kinsmen Special Infant Clinic for children born with an assortment of problems.

The **Kingston Firefighters Association**, together with **LOEB Princess Street**, raise about $6,000 to $7,000 every year for the Burn Unit through their Cola challenge, started in 1991. The firefighters build a fort of cases of LOEB Cola, sell the cases, and donate 60 cents per case to the Hospital. Other area firefighters from as far away as Brighton hold an assortment of fundraising events for the Burn Unit. The **Red Knights**, firefighters who ride motorcycles, donate proceeds of their events to the Burn Unit as well. The **Kingston District Shrine Club** has also donated funds to the Burn Unit for many years, and their assistance has been recognized through the naming of the unit as the Shrine Burn Unit. The Burn Unit is also the recipient of some of the **Independent Order of Oddfellows'** charitable gifts.

The **Police Association's** circus, held every year since 1987, usually raises from $20,000 to $50,000 every year. About $2,000 to $3,000 of the funds raised annually are earmarked for the update for the Poisondex System in the Emergency department, an index of poisons, a service taken for granted but in need of funding. Remaining funds are dedicated to paediatric equipment, including monitors and surgical equipment. Since 1987 the Association has given a total of $153,000.

The **Arts and Science Undergraduate Society** at Queen's University also operates regular fundraising programs in support of the Child Life Program.

Numbers of other groups also hold special events for the Hospital and its services, and their support is vital and very much appreciated.

BUILDING ON THE PAST 150 YEARS OF CARE

The mission and values of the RHSJ have moulded and shaped the Hospital to its form today. "The beginnings of Hotel Dieu Hospital were classic," says Executive Director Hugh Graham, "with the Sisters on a charity basis running a combination of orphanage, hospital and some educational functions; and over that 150 years it has evolved into one of the leading teaching hospitals in Canada with a very wide range of technology and sophisticated tertiary care services. Its history is in many ways a mirror of the evolution of the very best in medicine in Canada since the early days of the division of hospitals. Looking back 150 years to the three Sisters coming up the river from Hotel Dieu in Montreal and starting a hospital in a tiny building to a point where they have built, maintained, sustained a major teaching hospital and are now at the cutting edge of some of the most important ideas and concepts, it is a tremendous tribute to what the Sisters have achieved, to their ingenuity, flexibility and perseverance. I think it certainly answers those who perhaps say that maybe the Sisters have outgrown their need in the health care field."

TODAY'S CHARACTER AND ROLE

Although technological and financial factors have merged to influence the style of today's treatment, the care for the poor, the alcoholic, the convicted and the victims of social justice is just as evident in the RHSJ modern systems of health care as it was 150 years ago.

Today HDH finds itself in an extremely interesting, enviable, even avant garde position, according to Mr. Graham. The first is the fact that HDH, along with KGH, St. Mary's and Queen's University, has led the nation in consolidating, rationalizing and cooperating in the provision of a complete spectrum of health care for the people in this region.

The second is the fact that HDH and KGH are the only two hospitals in Canada that together make up a complete faculty of medicine for a major medical school, and that have now successfully implemented an alternative funding program.

Physicians have accepted specific job descriptions with fixed incomes attached instead of fee-for-service, a major innovation for medical cooperation. Removing the fee-driven aspect of medical care has been talked about in society, and the hospitals in Kingston are the first in Canada to achieve this.

THE SPIRIT OF THE SISTERS

The one regret felt by a great number of the longer-term staff is that the Sisters are far fewer and far less visible. When numbers were much larger and nursing units were supervised by Sisters, the traditions of caring became well established. However, the feelings of family, friendship, atmosphere and camaraderie are still present. People want the Sisters back in the Hospital because of the values, the environment and the whole attitude surrounding them, an attitude found not only in HDH Kingston but in the Sisters' hospitals across Canada and the United States. Whether RHSJ or other communities, the Sisters uniformly seem to be able to provide something special in the environment in a hospital that makes people feel comfortable, welcome and secure.

HDH has maintained its religious aspect, while becoming a more fully fledged teaching hospital and assuming more research responsibilities. Its Pastoral Care program is superb and unique, supporting those devastated by sudden death or in distress because of a critically ill family member.

One of HDH's real missions is to continue the values and ethics of the Hospital, even though the Sisters' physical presence is smaller. With much shorter hospital stays, in spite of all efforts the close "family" feeling is becoming slightly more distant. The Sisters' philosophy of health care is based on the principle of the basic dignity of every human person made in the image of God. These values must be maintained, if the Religious Hospitallers are to maintain and retain HDH as a Catholic-sponsored facility, a part of the Church's healing ministry. Because of the shrinking number of Sisters, the laity are being required to assume more of the positions in this healing mission in which the Hospital forms only one part. Outpatient clinics and other aspects of health care must also be addressed.

The ultimate decision-making responsibility for HDH rests with the Sisters, who comprise the Corporate Membership of the HDH Corporation. Canon Law requires the Corporate

Members, as a Catholic Hospital, to reserve to themselves certain canonical responsibilities relative to philosophy, mission, and specific temporal affairs. Sister Rosemarie Kugel, President of the RHSJ Health System, envisions future Corporate Membership of HDH to include dedicated lay people; persons with the same philosophy and values to serve in this leadership ministry.

"The Sisters certainly anticipate change. Many of the changes already experienced at HDH have come through collaboration with others," according to Sister Kugel. For instance, the Joint Liaison Committee, comprised of representatives from the Kingston health care institutions and Queen's University, plan and present recommendations to the individual governing boards regarding rationalization among the health care institutions, and recommend proposals for new programs and services to address unmet needs within the Kingston area. Future collaborative initiatives among the participants of the Joint Liaison Committee, as in the past, will require a commitment to respect Catholic corporate integrity, which includes ethics, values, and mission of HDH, as well as the mission of each participating member institution.

The Religious Hospitallers of St. Joseph wish to remain active in promoting a value-based approach to health care. Changes in health care are inevitable and welcomed. What motivates them today is not a nostalgia for past practices but a living commitment to a way of providing health care that includes many partners in mission.

FUTURE OF HOSPITAL CARE

For the future, the only thing constant is change.

Hospital care is changing at a pace never seen before. Almost every four or five years there are major changes in funding, technologies, expectations, length of stay, capabilities of hospitals. CAT scanners, MRIs and other new technology, and surgical procedures that permit a patient to appear in the morning and leave at night, were unthinkable 10 or 15 years ago. The uses of hospitals and the needs for hospital beds are changing quickly.

Like the entire health care system, HDH will face the problems created by the approaching wave of "young old" and "old old" people - the elderly in the last quarter of their lives

consume a very large percentage of all their lifetime need for hospital and health care. Much of this has traditionally been provided by hospitals. Hospitals tomorrow will not have the physical resources for the kind of care that was provided for people of 65 to 85 yesterday.

The biggest challenge for hospitals, including HDH, is to rationalize their services in conjunction with the other health care providers in the region, to make sure that available dollars are used for those things that only hospitals can provide, and allow other health care providers in the community to provide other services less expensively, closer to patients, their homes and the communities in which they live.

"We're finally coming to understand as a society that a hospital, regardless of how good the hospital is, is the last place you want to be, and the last place you should be," says Mr. Graham. "The first place you should be if you are ill or if you need care is at home. Hospitals should be the last answer. Other solutions are more economical and more efficient, and we've come to understand, particularly in the last 10 or 15 years, that they're much better for the patient."

FUTURE OF THE HEALTH SCIENCES COMPLEX

HDH has become an integral part of the Health Sciences Complex. The future of that Complex is somewhat clouded with immediate problems, but promises leadership of the region and of the province in change rather than just reaction to change, says Vice-Principal Duncan Sinclair. Today, it seems that the participants in the Centre have generated the necessary trust in the system and in one another to be able to work very well together without threatening one another's individuality. This trust could well be one of the keys to the future.

Costs of health and health care are very high, and future resources will be very constrained. The future is one of turmoil, says Sinclair. In every academic centre there is increased tension now between the longer-range objectives of education and research and immediate imperatives of patient care.

The medical system, and patients themselves, will have to discriminate between patient expectations and patient need. For many of the minor illnesses such as the common cold, chicken soup, aspirin and bed rest are as good as anything. Separating expectations from needs will also cause tension.

However, the Health Sciences Complex has an excellent base. HDH and KGH are the two most efficient teaching hospitals in the system in their respective group size, and still more efficiency can be attained. Much comes from the fact that services have been rationalized.

Dr. Sinclair foresees locally the extension of the reach of the academic Health Sciences Centre throughout the whole of southeastern Ontario, an outreach that has already started and is now stretching as far as Cornwall and Peterborough for some services. The northern outreach is expanding into Timmins. The Health Sciences Centre will play a major role in future plans for both the systems of health care delivery and the distribution of human health resources in the catchment area. The Centre not only provides a substantial amount of very highly sophisticated services, it has the capacity now, and will be developing more, to provide the data on which sensible plans rest.

Dr. Sinclair also anticipates the development of regional health councils, and a much closer association between their planning responsibilities and those of the Centre.

HDH will be a full partner in this planning and assumption of new responsibilities and new roles; yet it will always reflect the individuality and the mission of its founders.

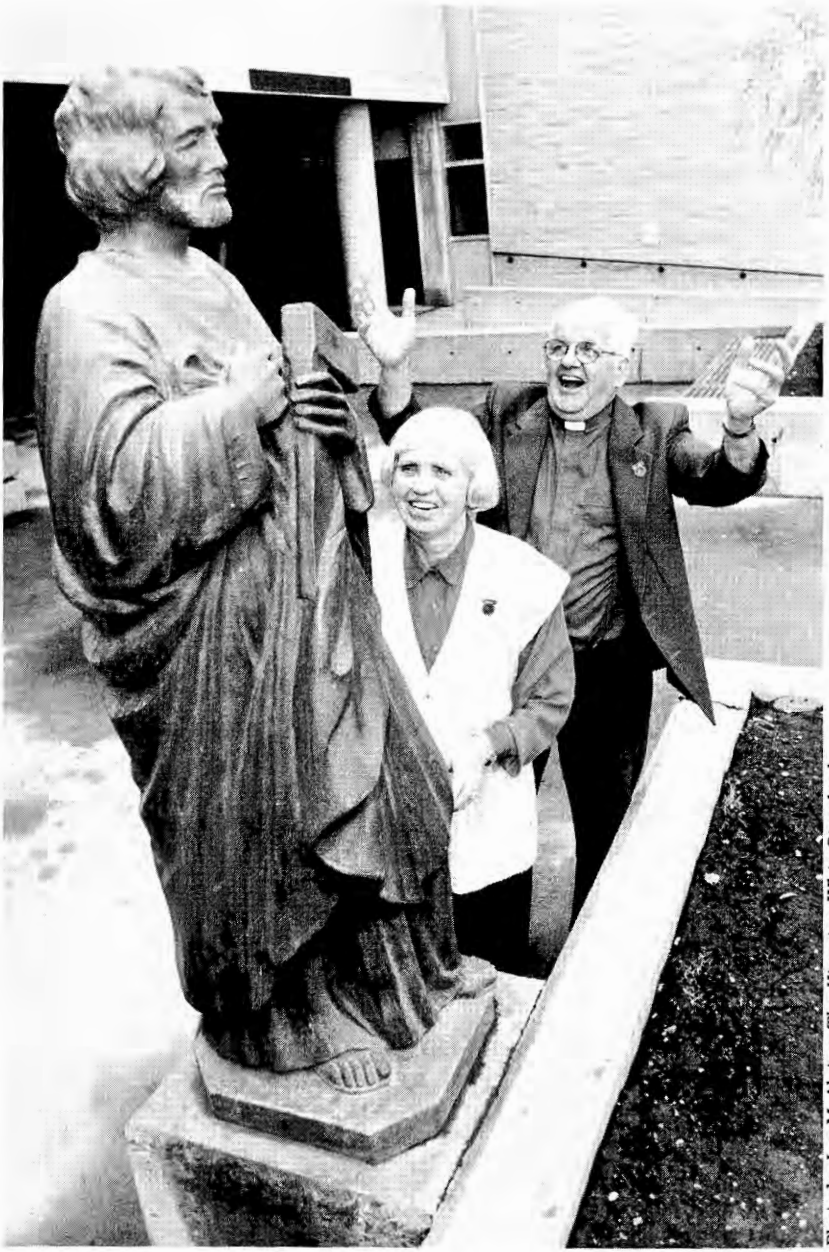


Photo by Ian McAlpine, The Kingston Whig-Standard

Sister Elizabeth MacPherson, Sister Liaison and Father Ken Stitt, Chaplain with statue of St. Joseph at Brock Street entrance, 1995.

APPENDIX 1

OUR VALUES

A STATEMENT OF COMMITMENT

Our values allow us to participate freely in the healing ministry of Jesus Christ. They guide us in establishing health care standards and motivate us to strive for the highest levels of excellence. They describe how we care.

We value our role in the healing ministry.

We each have a role in the healing ministry of this hospital. We are called to be sensitive and compassionate to the needs of others. We promote wellness for all our patients and those affiliated with this hospital.

We value and foster a community of caring persons.

Each person is worthy of our respect and we support one another realizing our strengths and weaknesses. As a community we function in a responsive and effective manner.

We value the sacredness of human life.

Every individual has the right of life from the moment of conception until death. Within the realm of our responsibilities, we try to prolong life to the best of our abilities. We recognize that death is a transition to another form of spiritual existence. We provide an environment where inevitable death can occur as peacefully as possible.

We value growth through education and human development.

Each person is special and is able therefore to make a unique contribution to our mission. We encourage personal development and education and support efforts in creativity and innovation.

We value stewardship which fosters responsible, ethical management of people and other resources.

It is our responsibility to use our resources wisely so that we may continue to fulfil our obligations for the sake of those requiring our help.

We value justice.

It is our responsibility to treat each person fairly. The services we offer are available to everyone. In particular we are sensitive to the needs of the disadvantaged and we act responsibly to those whom we serve.

We value our history and our heritage.

From the Congregation of Religious Hospitallers of Saint Joseph founded in 1636, we have inherited a mission which exemplifies faith, love, compassion, strength, endurance and commitment. It is these qualities on which with God's help, we will strive to build for the future.

From: "Hotel Dieu Hospital Annual Report, 1986-1987"

APPENDIX 2

CHRONOLOGY - TOUCHSTONE EVENTS

1841	Bishop Remigius Gaulin invites the Montreal Religious Hospitallers of St. Joseph to come to Kingston.
1845	Four Sisters establish Hotel Dieu Hospital - 229-233 Brock Street, under Foundress Sister Amable Bourbonnière.
1846	First expansion - 231 Brock Street.
1847	Almost 100 orphans (Irish typhus immigrants) arrive Christmas Eve.
1858	Dr. Michael Sullivan, Queen's Graduate 1858, Chief Surgeon, HDH.
1863	Montreal Sisters leave; new local Sisters in charge.
1868	Hotel Dieu incorporated after B.N.A. Act.
1870	Hospital enlarged with addition, present Brock Street Apartments (became first School of Nursing in 1912).
1875	Sisters Janet Macdonell and St. Joseph Leahy to Montreal to study Nursing.
1892	Sisters move to renovated Regiopolis on Sydenham.
1894	Present Chapel built.
1898	Sisters' Monastery built on Johnson Street.
1899	Modern operating theatre with private entrance for medical students.

1902	Fourth agreement with Queen's University signed.
1905	Ladies Auxiliary founded.
1909	Brock Street wing, corner of Brock and Sydenham, opens.
1910	Obstetrical Unit opened. Orphans move to Sisters of Providence.
1912	St. Joseph's School of Nursing established.
1920	Hotel Dieu accredited by American College of Surgeons.
	75th Anniversary celebrated at Hotel Dieu.
1923	New Nurses' Home built
1931	St. Joseph wing added.
	Public Hospital Act Ontario enacted.
1935	Campion School of Medical Record Librarians, first in Canada, opened.
1944	Department of Veterans Affairs wing added.
1945	Centennial celebrations.
1948	Jeanne Mance Residence built on Brock Street.
1949	School of Medical Technology opens.
1950	Centenary wing opened.
1951	Advisory Board in place - J.M. Hickey first Chairman.
1959	Sisters move from Monastery to 1923 Nurses Home.

1959	Interns move to 176 Johnson Street.
1962	Sydenham wing closed to patients; bed count 319. 42 bassinets.
1966	Johnson Street wing opens.
	Mr. Eric Brown, first lay CEO, at Hotel Dieu Hospital.
1973	Obstetrics moves to Kingston General Hospital.
	School of Nursing moves to St. Lawrence College.
1976	Family Medicine officially opened at corner of Bagot and Johnson Streets.
1981	Jeanne Mance Foundation and Le Royer Patrons founded.
1983	Opening of Detoxification Centre.
1984	Official opening of Jeanne Mance wing by Premier William Davis.
	RHSJ Health System.
1985	Opening of Geaganano House, 176 Johnson Street.
1989	David Peterson, Premier of Ontario, dedicated CT Scanner and refurbished Ivan T. Beck Unit (Gastroenterology).
1993	The T. Frank McElligott, M.D., Clinical Laboratories blessed by Most Reverend Francis J. Spence.
	Re-dedication of 1894 Chapel.

1994 The William R. Ghent, M.D., Operating Room Suite and Surgical Stepdown Unit blessed and re-dedicated.

Prepared by: Sister Loretta Gaffney, R.H.S.J.;
Heather M. Gordon;
and Mary Millar.

APPENDIX 3

LIST OF SOURCES

Archival Sources:

Annals and chronicles of the Hotel Dieu Hospital Community, Kingston. RHSJ Archives, Amherstview.

Bishops Gaulin, Phelan and Bourget letters, RHSJ Archives, Amherstview. Photocopies.

Dwyer-Sepic, Patrice. "Child Welfare Institutions in Kingston in the Last Half of the Nineteenth Century and the Role Three Women's Groups Played in their Establishment, Ideology, Administration and Implementation." Paper prepared for History & Philosophy of Social Welfare, Carleton University. November 1984.

RHSJ Health System fonds. RHSJ Archives, Amherstview.

Hotel Dieu Hospital Kingston fonds. RHSJ Archives, Amherstview.

Hotel Dieu Hospital Montreal annales. RHSJ Archives, Amherstview. Photocopies.

Queen's University Archives.

Oral History: Tape-recorded Interviews by Author at Kingston, Ontario:

Anson, Patty. 14 June 1994.

Ashworth, Dr. M. Anthony. 16 August 1994.

Beck, Dr. Ivan. 1 June 1994.

Botterell, Dr. Harry. 4 November 1993.

Boudreau, Gerard. 29 April 1994.

Braden, Marilyn. 6 June 1994.

Burr, Dr. Ronald C. 25 November 1993.

Coderre, Sister Mary, R.H.S.J., and Sister Loretta Gaffney, R.H.S.J. 10 February 1994.

Da Costa, Dr. Larry. 29 June 1994.

Dagnone, Dr. L. Eugene. 6 July 1994.

Ferguson, Ann Ryan. 21 January 1994.

Ghent, Dr. William R. 12 July 1993.

Gibson, Rose Mary. 16 June 1994.

Graham, Andrew. 8 September 1994.

Graham, Hugh. 12 September 1994.

Hall, Dr. Stephen. 1 September 1994.

Hanley, Monsignor J.G. 31 December 1993.

Hartnett, Eileen. 1 June 1994.

Hazlett, Dr. John. 29 August 1994.

Keevil, Sister Kathleen, R.H.S.J. 22 September 1994.

Kelly, Dr. H. Garfield. 26 October 1993.

Kugel, Sister Rosemarie, R.H.S.J. 25 August 1994.

Leonard, Sister Evelyn, R.H.S.J. 3 February 1994.

Little, Maureen. 2 June 1994.

MacPherson, Sister Elizabeth, R.H.S.J. 22 December 1993.

Markowski, Theresa. 11 August 1994.

McLean, Mary. 20 June 1994.

McNeil, Sister Margaret, R.H.S.J. 8 June 1994.

Milliken, Dr. John. 1 February 1994.

Pinch, Audry, and Marg van Hoosen. 3 August 1994.

Rouse, Midge. 18 July 1994.

Sanborn, Marg. 3 August 1994.

Sinclair, Dr. Duncan. 31 January 1994.

Smith, Winnie. 18 August 1994.

Sorbie, Dr. Janet. 22 June 1994.

Spence, George. 22 June 1994.

Stitt, Father Ken. 1 September 1994.

Struzzo-Jones, Norma. 24 June 1994.

Tidman, Thea. 29 August 1994.

Taylor, Dr. Don. 25 August 1994.

Thompson, Margaret. 17 February 1994.

Waring, Dr. Ted. 18 July 1994.

Wells, Janice. 8 September 1994.

Wherrett, Dr. Brian. 26 August 1994.

Wilson, Ruth. 24 June 1994.

Workman, Dr. Donald. 23 August 1994.

Wren, Dr. Simon. 22 July 1994.

Newspapers and Newsletters:

Hospital Bulletin.

Hotel Dieu Hospital Bulletin.

The Bulletin.

Hotel Dieu Hospital Newsletter.

Hotel Dieu News.

The Dieu Line.

Dieu News.

Update.

The Kingston Whig-Standard.

Kingston This Week.

Canadian Register.

Published Sources:

Annual Reports. Kingston, Ontario: Hotel Dieu Hospital.

Bechard, Henri, S.J. *Jérôme Le Royer de la Dauversière : His Friends and Enemies.* Bloomingdale, Ohio: Apostolate for Family Consecration, 1991.

Coderre, Sister Mary, RHSJ. "Hotel Dieu of Kingston: Past, Present and Future." *Historic Kingston 35* (January 1987): 3-14.

The Customary and Little Rules of the Religious Hospitallers of the Congregation of St. Joseph: From the French Edition Published by E. Jourdain, La Flèche, 1850. Kingston: privately printed, 1901.

Daveluy, Marie Claire. *Jeanne Mance: 1606-1673.* Collection fleur de lys: études historiques canadiennes, ed. Guy Frégault et Marcel Trudel. Montréal: Fides, 1962.

Deslauriers, Jessie. *Like a Bay Tree, Ever Green: The History of St. Joseph Province, Religious Hospitallers of St. Joseph.* Kingston, Ontario: Privately printed, 1984.

From Words to Loving Action..: The History of 75 Years of Dedicated Service of the Volunteer Services to Hotel Dieu Hospital, Kingston, Ontario, 1905-1980. Kingston, Ontario: Privately printed, 1980.

Hacker, Carlotta. *The Indomitable Lady Doctors.* Toronto: Clarke, Irwin & Company Limited, 1974

Hospitals Division of the Department of Health, Ontario. *The Hospitals of Ontario: A Short History.* 1934.

Jeanne Mance : The Woman, the Legend and the Glory. Kingston, Ontario: The Bronson Agency, 1984.

McMahon, Nancy. "Les Religieuses Hospitalières de Saint Joseph and the Typhus Epidemic, Kingston, 1847-1848." *The Canadian Catholic Historical Association: Historical Studies*. 58 (1991): 41-55.

Raby, Tom. *More of the Little World of Father Raby*. Kingston, Ontario: Privately printed, 1980.

St. Joseph's School of Nursing: 1912-1974. Kingston: Privately printed, 1974.

Travill, A.A. *Medicine at Queen's 1854-1920: A Peculiarly Happy Relationship*. Kingston, Ontario: Faculty of Medicine, Queen's University and The Hannah Institute for the History of Medicine, 1987.

The author, Jessie V. Deslauriers, is a freelance writer, columnist and editor living in Kingston. She has two other books to her credit: "Like a Bay Tree, Ever Green", and "The Beach Commitment: A Man and His Company". A former staff member of Queen's University, a member of Queen's University Council and of the Kingston Symphony Association Board of Directors, she holds a B.A. and a B.Sc. She is the daughter of Toronto newspaperman and author Jack Hambleton and is married to Andre, a former Royal Canadian Air Force officer. When not busy at her computer, she enjoys birdwatching and growing orchids on the kitchen windowsill.

Photographer:
Preston Schiedel, Preston Schiedel Photography, Kingston, Ontario.