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Newfoundland and Labrador: The Paradoxical “Sick Man” of Canada

J.T.H. Connor

Stephen Bornstein, John Abbott, Victor Maddalena, Aimee Letto, Melissa Sullivan, and Pablo Navarro. *Newfoundland and Labrador: A Health System Profile*. Toronto: University of Toronto Press, 2021. ISBN: 978-1-48752-585-9

Newfoundland and Labrador: A Health System Profile is, at heart, a reference work. Its voluminous statistics, charts, tables, factoids, lists, data, boxes, and abbreviations comprise the most up-to-date collective picture of the province's health-care infrastructure. In brief, it is, to invoke a current phrase, a health-care policy “report card.” Accompanying these features is helpful textual analysis; yet, if readers tackle this book uninterruptedly (as opposed to occasionally dipping into it for particulars, which is greatly facilitated by an exhaustive index), they might find the task a bit tedious. Such was the case for me, even as a seasoned medical historian. This acknowledgement, however, prompts the question why *I*, given my disciplinary background, am reviewing this book.

To respond (and not defensively): First, it is routine for historians of medicine to analyze government documents, policy statements, statistical reports, clinical data, medical institutional records, and so on, so the matter presented in this book is all comprehensible. Second,

although the book is about health policy, it is in part historical in structure; a portion of it attempts to capture the development of Newfoundland and Labrador's health-care infrastructure since the 1930s. Third, I believe that any review of *A Health System Profile* should take a much broader intellectual perspective than the narrow facts and figures it presents — how has health care of Newfoundland and Labrador, along with the health of its inhabitants, changed (or not) over time? What are the big trends over the long run, not just, for example, those of the last decade? Relatedly, it strikes me there is a good argument for a comparison between this 2021 publication and previous historical sources. Finally, and perhaps most important, one of the book's significant conclusions addresses the “Newfoundland paradox.” This paradox arises from the tension between the fact that every standardized and objective biomedical/scientific metric used to gauge the health status of any population demonstrates that Newfoundland and Labrador is the unhealthiest province in Canada, and that individuals living there steadfastly believe they are the healthiest of people. The paradox that this jurisdiction can be labelled the “sick man” of Canada, but yet is also one rejected by its people, I will argue, has curious and interesting historical parallels.

Newfoundland and Labrador: A Health System Profile appears in the North American Observatory on Health Systems and Policies (NAO) publication series under the general editorship of Gregory P. Marchildon, the renowned Canadian former government health-care executive administrator, historian of medicare, and founding director of the NAO, and who held the position of professor and Ontario Research Chair in health policy and system design at the Institute of Health Policy, Management and Evaluation, University of Toronto. The NAO focuses attention on “state [in the US] and provincial [and territorial] health systems . . . to creat[e] a foundation for more systematic health system and policy comparisons among substates.”¹ To date, published provincial studies address Nova Scotia and Alberta, in addition to Newfoundland and Labrador. The completion of the NAO project will presumably allow comparison of similar health-care apples across

Canada, assuming they are picked at roughly the same time. All six co-authors of *Newfoundland and Labrador: A Health System Profile* are residents of the province. Bornstein, a political scientist but now since retired, was founding director of the Newfoundland and Labrador Centre for Applied Health Research (NLCAHR), which is a unit within the Faculty of Medicine, Memorial University of Newfoundland (MUN); Abbott has been provincial deputy minister of health and community services, and is currently minister of children, seniors and social development, minister responsible for the status of persons with disabilities, minister responsible for the community sector, and minister responsible for the Newfoundland and Labrador Housing Corporation; Maddalena is associate professor of health policy in MUN's Faculty of Medicine; Letto is legal counsel for the Newfoundland and Labrador Medical Association (NLMA), although not specifically identified as such in the book; and Sullivan and Navarro are health policy researchers, the latter employed by NLCAHR.²

A Health System Profile: What the Book Tells Us

The book's structure follows the template of its sister volumes in the NAO series. An introductory chapter explores the province with respect to geography and sociodemography, political and economic contexts, and the health status of the population. The following chapters analyze the structure of health care and its delivery regarding organization and regulation (this section includes the most historical parts of the book): health spending and financing; physical infrastructure; health human resources; services and programs (the book's largest section); reforms; and assessment and review of the health systems. There is also a brief conclusion. This comprehensive approach ought therefore to interest a broad readership, including political scientists, economists, health policy analysts, sociologists, cultural anthropologists, and reflective health-care practitioners and administrators. One might also hope that this study will circulate in local political circles as the province was, at the time of the book's publication, the only one in

which both its premier and its minister of health were licensed physicians (although Minister of Health John Haggie would be replaced in July 2022). Moreover, as one of the co-authors (Abbott) is now a cabinet colleague with several related ministerial portfolios, I would surmise that at such executive levels plausible deniability of the book's content might be difficult! Looking to the future, this volume, indeed the whole series it appears in, should become a valuable resource also for historians owing to its panoramic snapshot at a particular time of a specific and important aspect of the nation and its constituent provincial and territorial jurisdictions.

From the across-the-board perspective, numerous conclusions are drawn about the province's health-care infrastructure, functionality, and effectiveness, along with the contours of the health of the people of Newfoundland and Labrador. Overall, the big medical administrative picture depicted in *A Health System Profile* is not of a healthy and rosy province. From start to finish the authors' analysis is punctuated with normative terms such as "bleak," "challenges," "challenging," "very challenging," "difficulty," "stretched thin," "slow and hesitant," "incremental change," "rather disappointing," "worst in the country," "lags behind," "less than ideal," "comparatively poor," "considerable room for improvement," and "resistant to fundamental reform." On the one hand, if *any* health system in *any* jurisdiction were subject to rigorous scrutiny it probably would be found wanting, as demand for services will always exceed availability; costs of operation will typically be less than that budgeted; advanced medical technologies will constantly be in need of replacement; and the complement of qualified personnel will always be fewer than ideally needed. On the other hand, the issues identified with the health system of Newfoundland and Labrador appear to be deep-rooted, long-standing, and systemic — and, most worrisome, apparently irremediable.

In advance of explicating these shortcomings, it is helpful to describe first the broad setting, context, assets, and framework of the province's health system. The main pillar is the physical health-care infrastructure scattered across the island and mainland Canada (Labrador), which

totals 226 facilities consisting of public health laboratories (37), hospitals (15), health centres (23), long-term care facilities (21), treatment centres (5), primary health-care centres (66), and community-based service locations (59). For the decade beginning in 2004, the provincial government spent most of \$1.5 billion on modernizing these holdings. Also during this period, the purchase of sophisticated new diagnostic equipment accounted for much additional significant spending: CT scanners (16), digital mammography units (16), and MRI machines (5), along with a PET/CT scanner for use in cancer care. On the one hand, many of these devices are distributed across the province, allowing patients relatively convenient access; indeed, considered on a per capita basis the authors claim that NL has the highest number of CT scanners per million population. On the other hand, as they also point out, equipment such as the PET/CT scanner is located solely in St John's, so people must travel to it from wherever they live across the entire expanse of the province.

A second health-care infrastructure pillar is its virtual/digital capabilities, encompassing the electronic health record, telehealth, the picture archiving and communication system, the pharmacy network, the laboratory information system, and the client registry. Ideally, the collective functioning of these databases, electronic networks, and record retrieval systems ought to result in health-care practitioners being able to access information in a timely and seamless way, regardless of their geographic location. In reality, however, like aspects of the aging physical infrastructure that have been subject to recurring failure, online elements, too, are precarious and in need of attention. The authors note many of these tools, especially the development and implementation of the electronic health record (EHR), also lag when compared to national statistics. In 2018, only about 10 per cent of physicians in NL used the EHR, which was the lowest uptake nationally at that time. Whatever else accounts for this low figure, the absence of a robust province-wide high-speed digital Internet/telecommunications system is a factor. (The recent cyberattack on the complete online system of the largest health authority, which for a considerable

period wiped out everything stored along with the theft of patients' private data, underscored the fragility and vulnerability of the health-care infrastructure's virtual/digital capabilities.³⁾

A third pillar is the assemblage of health-care entities involved in gathering information, surveillance, evaluation, and research. Ten distinct units undertake these functions, which according to the authors is a "surprisingly large number" (68), presumably for the size of the population but the statement is not elaborated on and left hanging. Several agencies are directly or indirectly linked to Memorial University's Faculty of Medicine (e.g., Primary Healthcare Research Unit; Health Research Unit; NLCAHR); several are connected to the Eastern Health Regional Health Authority (e.g., Janeway Pediatric Research Unit; Department of Research); and others are provincial government agencies, departments, or Crown corporations (e.g., Planning, Performance Monitoring and Evaluation Division of Health and Community Services; Centre for Health Information and Analytics; NL Centre for Health Information). As a result, there appears to be no shortage of highly qualified policy personnel scrutinizing, analyzing, criticizing, recommending, and reporting on the effectiveness and problems of NL's health-care system. But with what operational results? The authors put forward dismal conclusions respecting change, reform, and improvement: "progress on administrative restructuring in the province has been slow, featuring multiple consultations and frameworks but with limited amounts of actual change" (116); "reforms lagged, and the little progress that had been achieved did not translate into broader change at either the regional or the provincial levels" (117); and "Newfoundland and Labrador governments, regardless of political party, have undertaken few major health reforms and have . . . resisted suggestions that radical change is needed" (121). Reasons cited by the authors for such entrenched reticence will be discussed in a later section.

The importance of technological and built assets notwithstanding, the personnel on the ground who routinely care for the population they serve, along with the depth and breadth of the essential medical

services they deliver, are the indisputable backbone of any health-care system. Under the heading of the workforce and its organizational structure, aspects of NL's health-care system reportedly display distinctive features, which, owing to historical, geographic, and sociodemographic reasons, occasionally diverge from national norms; NL may not be wholly exceptional with respect to the rest of Canada, yet it remains somewhat idiosyncratic. Approximately 32,000 health-care workers comprise the whole system, with about 65 per cent of them distributed across the four regional health authorities (RHAs) created in 2004 (before that date there were 14): Labrador-Grenfell (1,500), Central (3,000), Western (3,100), and Eastern (13,000). In 2023 these RHAs were further amalgamated into a single provincial health authority. Most of the total work complement is unionized (93 per cent), while women constitute the majority of workers (83 per cent); nurses (RNs and LPNs) are the largest single occupational group (40 per cent of the employees in RHAs).

Comparison of provincial physician and nurse ratios to total population leads to, initially, surprising results when contrasted with national statistics. With its approximately 1,300 practising physicians (roughly split evenly between family doctors and specialists), NL has the highest physician-to-population ratio in Canada (248:100,000 versus 230:100,000). Similarly, the provincial nurse-to-population ratio is 1,610:100,000 as compared to 1,174:100,000 nationally. These figures are, of course, wholly misleading, as *A Health System Profile* points out, because the overwhelming majority of physicians and nurses (and most other health-care practitioners for that matter) are located in the Eastern RHA — and there, they are mostly clustered in and around St. John's. Taking into account, then, the larger picture of the geographic distribution of the health-care workforce, a much leaner situation prevails in which access to needed services is, at best, challenging. Considered at the most general level, however, services and programs available to the overall population are comprehensive, with the “province's ‘basket’ of covered services . . . quite similar to those of other Canadian jurisdictions” (113).

But what does all this cost? Reading the results of analyses of health-care expenditures and financing is not for the faint-hearted or the lily-livered. Residents of NL pay more per capita on health care than those living in any other province. Fully 42 per cent of the province's annual budget is spent on health care (around \$4 billion), which is still 10 per cent higher than what it spends on debt financing, public education, and post-secondary education combined. In the authors' opinion, such "current levels on spending on health will be very hard to sustain" (48) taking into account the province's parlous financial circumstances. Constantly topping the charts are hospitals and other institutions, which account for just under half of the total health budget; physicians and other professionals cost 18 per cent; drugs cost 14 per cent; and capital expenditures, public health, administration, and other health spending take up the remaining approximately 25 per cent. This spending pattern is *generally* similar to other Canadian provincial budgets, but the province's expenditure on hospitals exceeds the national average of 28 per cent (compared with 36 per cent for NL). A combination of geographic reasons and an elderly population suffering more from chronic diseases help explain this situation, but so, too, does "longer than average hospital stays linked to inefficient discharge processes" (50).

In review, *A Health System Profile* demonstrates, first, that the health-care system of NL is expensive and above the national cost average, is a significant drain on provincial coffers, is in need of physical and technological refurbishment, is spread thin geographically, is understaffed, and remains all but impervious to radical reform. Yet, for all those negative conclusions, this health-care system works — well, sort of. And it would *appear* that collectively Newfoundlanders and Labradorians are sort of accepting of a system that sort of works. This is where things, health policy-wise and otherwise, get tangly! As already noted, regardless of whether Conservatives or Liberals were in power, the authors argue there was no political appetite displayed by them for health-care reform, especially any type of radical change to the system. They highlight how political "personalities and leadership"

dominate over policy, and that "party leaders have rarely paid much attention to health issues except for the occasional gesture towards the high cost of the province's health system" (121). Second, popular and public media have been relatively silent and ineffectual in any role of holding politicians accountable for such inaction: "health reform has never been a burning issue in the public mind" (122). "None of the province's radio, television, or print media," the authors report, "has a journalist with sufficient expertise whose attention is focussed, even on a part-time basis, on health or on the performance of the province's health system" (123).

Third, the almost total unionization of the health-care workforce has similarly mitigated against radical change. The main bargaining goal of the several unions that represent tradespeople, clerical, managerial, and technical workers, along with the powerful nurses' union, has been on remuneration, not reform. Similarly, the attention of the NLMA, which is also the doctors' bargaining unit, has been on the "remuneration and the protection of its members' incomes and clinical authority," thus it has "served as an obstacle to rather than a facilitator of reform" (122).

Finally, the icing on this layer cake of complacency is the collective self-diagnosis of the province's residents that they are personally healthier than fellow Canadians, as expressed in national and provincial polls. Thus, they are satisfied with the health care they receive and the system that delivers it. But, in reality, NL is the sick man of Canada, similar to Scotland, which recently was labelled the sick man of Europe — as measured mostly by the same health parameters.⁴ *A Health System Profile* catalogs and enumerates how provincial rates of unhealthy lifestyles, including poor dietary habits such as the low consumption of fresh fruit and vegetables, heavy smoking and drinking, low physical activity, and excessive obesity, far exceed national averages. NL also has the country's highest rates of circulatory diseases, cancer, and diabetes. It is this tension between popular perception and statistical reality vis-à-vis health that defines what the authors coin the "Newfoundland paradox," which "involves the coexistence of comparatively poor scores on many, if not

most, population health and health system performance indicators with comparative high levels of satisfaction expressed by Newfoundlanders and Labradorians” (136).

A Health System Profile: What the Book Does Not Tell Us

Using prevailing policy and current statistics as analytical tools to portray a snapshot of health systems and population wellness is useful, but that lens is a short and tight one. Viewing the same scene through the longer lens of history offers another perspective, which *A Health System Profile* very briefly attempts. Including this additional vista is laudable in theory, but remains disappointing in practice as the few pages forming the book’s historical section are founded on factoids derived from mostly popular history websites based on material prepared by non-academic historians. The potted history and vignettes suggest that nothing much happened regarding population and community health before the 1930s, excepting the activities of Wilfred Grenfell and his International Grenfell Association (IGA) in northern Newfoundland and southern coastal Labrador, along with a network of public health nurses paid for by the sale of knitted garments. During the era of the Commission of Government (1934–49), the few existing hospitals (for example, in St. John’s, Twillingate, and Grand Bank) were augmented by the government-sponsored cottage hospital system. Eventually almost 20 cottage hospitals were built in coastal communities, and were typically serviced by a couple of physicians and several nurses; collectively, they cared for a sizable portion of the rural and remote population (up to 200,000 people). In the post-Confederation period of the 1950s and 1960s, health-care delivery expanded to include new larger hospitals and other facilities in Corner Brook and St. John’s, as well as the creation in 1967 of a medical school for Memorial University. In the decades following the 1970s, the health-care system underwent considerable restructuring and reorganization along the lines of regionalization, which was the norm for other Canadian provinces.

Unfortunately, this somewhat anemic historical account results in a missed opportunity as understanding the structure, functioning, and distinctiveness of any current health system needs to be truly grounded in a sound scholarly medical historical context. This essay is *not* the place to present a deeper, synthetic overview of the medical history of Newfoundland and Labrador; yet, in comparison to what *A Health System Profile* presents, I will show how an exploration of three topics addressed in this book demonstrate interconnections, major changes, and perhaps also continuities. This exercise also allows consideration of the extremely thorny historical problems of assessing "improvement" and "progress" with respect to health matters.

First, we need to tackle the so-called "Newfoundland paradox." As expressed in *A Health System Profile*, this phenomenon is a current enigma grounded in recently reported poll data, and is a particularly distinctive feature of the province's (bad) health culture. But casting an historical eye over it reveals a pattern of behaviour stretching back at least eight decades to the 1940s. The analytical framework adopted is not quantitative; rather, it is a qualitative methodology, and is grounded in the voice of popular protests and public criticism. The three episodes examined centre on the diet of Newfoundlanders, a central element of good health. When renowned Norwegian author and novelist, Karl Ove Knausgård, visited St. Anthony in 2015 on assignment for the *New York Times*, he excoriated local residents over their excessive obesity. He wrote that Newfoundlanders were the fattest people he had ever seen, and was dumbfounded as to how they grew to such gross proportions. Tracking the reaction of Newfoundlanders in popular media revealed a string of invective and vitriolic commentary against him and his homeland. In essence, the *vox populi* was one of denial, despite the medical truth of the matter.⁵

An analogous situation centres on Newfoundlanders' culinary predilection for pickled or cured red meats (e.g., Jiggs dinners, salt beef, bologna, and Vienna sausage), which has been correlated to the province's excessively high rate of colorectal cancer (CRC). The introductory section of a recent scientific publication noted that "Compared with

the rest of Canada, NL is geographically isolated and has a homogeneous population of which 98% are of English or Irish descent.” It continues:

Due to distinct geography and heritage, NL is known for its traditional foods and one such is pickled meat. . . . In NL, pickled meat can be either homemade or purchased from farmers markets or supermarkets. While little has been written about the distinct dietary characteristics of Newfoundlanders and Labradoreans [*sic*], given the frequency and quantity of picked [*sic*] meat consumption, NL is probably matched by no other populations in the world. This not only makes the population of NL ideal for the study of the association between pickled meat and colorectal cancer, such a study also has public health implications in terms of identifying important modifiable risk factors of CRC in this population.⁶

In their brilliantly witty commentary (tantamount to a denial), the popular band Buddy Wasisname and the Other Fellers sang about Newfoundlanders as “Salt Beef Junkies.” Verses of the well-liked song lampooned, satirized, and ridiculed medical evidence that pickled meat was unhealthy, concluding defiantly:

I don't want to be some health food freak who eats alfalfa
and bean sprouts
I don't want to live to a hundred and three if I got to
throw my beef out
When it comes right down to preparing food I don't
want to germinate or shuck it
I'll take my chances on salt beef dinners and keep my
head in this bucket.⁷

(Note to non-Newfoundlanders, the last line contains a local pun: salt beef is typically bought in bulk by the plastic bucketful.)⁸

Historical evidence for the existence of the “Newfoundland paradox” can be traced back further. In the 1930s and 1940s, segments of the population were the object of research scrutiny by American, British, and Canadian medical scientists who maintained that Newfoundlanders’ diet was inadequate and that they suffered from malnutrition. These research expeditions were intrusive and extensive, so much so that a British medical journal labelled the Newfoundland population the “most studied in the world.” One investigation conducted in 1944–45 was notorious as it concluded all Newfoundlanders were malnourished, physically stunted, and mentally retarded; indeed, people were so incapacitated that they were unable to work on building the World War II military installations on the island. Almost immediately after the study’s publication in the *Canadian Medical Association Journal* (CMAJ), it became front-page news across Canada — and, of course, across Newfoundland. Ignoring its kernels of truth of the then general diminutive stature of Newfoundlanders, their poor and unvaried diet, and their limited education, local newspaper editorials and articles lambasted the study with denials, expressions of righteous indignation, and repudiations.⁹

Appearing amid this furor was a clever piece of satirical doggerel, akin to “Salt Beef Junkies,” entitled “Your Constitution’s Down,” which appeared in the St. John’s *Evening Telegram*, then was republished in none other than the CMAJ. The six verses and repetitive chorus could all be sung to the universally known tune for the “Kelligrews Soiree.” The song was “dedicated to the memory of the Nutrition Survey report,” and its clear message was that all the recent discussion and ballyhoo about vitamin deficiencies and malnutrition among Newfoundlanders was bunkum; the chorus and two selected verses capture its spirit:

Chorus:

*Shun screech, wet feet, don't forget to clean your teeth,
Beer in moderation, stay in after tea,
Fish and brewis we must refuse for whole wheat grains and
citrus foods,*

The one sure way to vitalize with A, B, C, and D.

...

Now, Junior, next time you 'fall in', best come home on the
run.

Don't stand around in dripping clothes to watch the 'swoi-
lin' guns;

You've never had a cold, 'tis true, but Mom's scared you will
drown,

For you're mentally deficient and your constitution's down.

...

I'm going to tell your Grandpa who has just turned eighty-
four,

That he mustn't haul the cod-trap or cut firewood any-
more,

He might get the rheumatics, but he won't be muscle-bound,

For you don't develop any when your constitution's down.¹⁰

The plural of anecdote, as the phrase goes, is not data. Merely accumulating additional incidences of what plausibly might be examples of the "Newfoundland paradox" does nothing to explain it. But their review perhaps gives a hint to a feature of the collective psyche of the population that *A Health System Profile* does not. The repeated rejection, denial, and refutation of bad scientific news across time is revealing. It could be explained by simply assuming the total ignorance of the people about the "facts" being put forward, but that explanation is, surely, facile. Perhaps, a collective anti-intellectualism was at play where traditional folkways of knowing eclipsed those of know-it-all scientific experts — a quite likely possibility. Being lectured to by "outsiders," "mainlanders," or "CFAs" may have invoked a wilful domestic response to counter or undermine their information — also not an unlikely reaction. It strikes me, however, that a more substantive explanation involves the notion of cognitive dissonance or "doublethink." The journalist and prominent public intellectual Fintan O'Toole observed that within an Irish cultural context it is not in any way atypical for the population to know about something but simultaneously and

consciously *not* know about it, especially if that something is likely to significantly challenge or disrupt society’s status quo. A consequence of the powerful pervasiveness and indoctrination of Roman Catholic theology to safeguard the Church from blame, criticism, and reproach, the expression of this double state of mind aiding in reconciling the often irreconcilable can be manifest in more politically authoritarian and controlling regimes for the same reason.¹¹ Whether this insight can be applied to explain the “Newfoundland paradox” might be a matter for social psychologists, cultural anthropologists, or sociologists to more fully ponder.

A second issue requiring more analysis than received in *A Health System Profile* is an historical exploration of the function and role of the medical school within the province. References to the Faculty of Medicine at Memorial University in St. John’s are merely made in passing in *A Health System Profile*, which notes that it became operational in 1967–68, eventually would have an annual intake of 80 undergraduate MD students, and would in time develop numerous post-graduate residency specialist programs. Emphasized is the medical school’s role as a domestic pipeline for the production of doctors who choose to practise in NL, despite the fact that the province is second only to Saskatchewan as the home of the largest number of international medical graduates (IMGs). This portrayal is accurate as far it goes, but its superficiality results in a grossly inadequate representation, especially as one of the aims of this book is to identify the distinctiveness of the health system it aims to profile.

To my mind, a sound historical argument is to be made that the medical school is not just a local doctor factory, but is the keystone to the current health-care system in NL — as was envisaged by its framers, founders, and fathers (yes, at the time there was an entrenched patriarchy). As medical historian of health policy Dan Fox has made clear, the concept of regional hierarchy drove thinking about the necessary nexus of the function of the teaching hospital and that of the medical school for most of the twentieth century in the UK, the US, and Canada — and, in due course, Newfoundland. “[R]egionalization

became a means to organize personal health services,” Fox writes. “There was a consensus in the postwar years that treating illness and extending life should be accorded absolute priority in social policy.”¹² Within this medico-social framework, the medical school–university hospital complex, or what would become known as an academic medical centre, reigned supreme. Fox explains:

Hierarchical regionalism remains fundamental to health policy. . . . The assumption that knowledge that will lead to better health is usually discovered in university and hospital laboratories continues to guide investment in facilities, equipment, and personnel for medical research and education. The assumption that the results of medical research are disseminated most efficiently down hierarchies dominated by teaching hospitals is still the basis of policy to plan and build general hospitals and health centers and to link doctors to them. The assumption that consumers are entitled to receive services of increasing sophistication and cost continues to drive policy to finance medical care.¹³

The philosophy of hierarchical regionalism and the policies derived from it had special purchase for health-care delivery in rural and remote regions. In Canada, health-care development in Saskatchewan in the mid-1950s is a prime example.¹⁴ Newfoundland, a decade later, is another, as medical school planning and feasibility documents ably demonstrate. The several commissioned reports prepared by international medical authorities in the mid-1960s underscored the necessity and centrality of founding a medical school at MUN, which was to be understood as not merely another constituent element of the university qua educational institution. Its future role had to be much more integrated with society: “Inasmuch as a medical school in Newfoundland, considering its geography, will be called upon to make an important contribution to the health of the community, [its dean] should be willing to explore and seek solutions to the problems presented by the

needs for medical care of the people of Newfoundland. . . . The medical school should be developed as part of a plan for the future of medical care in Newfoundland.”¹⁵

These same reports further called for the simultaneous building of a new university hospital adjacent to the medical school, thus creating an academic medical centre on campus in St. John's but which would become the hub of tertiary health care for the province along spokes connecting it to distributed primary and secondary health-care facilities. There was a consensus that existing hospital facilities in the city were inadequate for teaching purposes due to their limited size and denominational ownership/organization (e.g., Catholic or Salvation Army); thus, a new, independent stand-alone institution was required. “It will be seen from the important responsibilities given to the University Hospital that it will, in fact, set out the pace and determine the standard of medical care throughout the whole province” noted one report. It continued: “*The whole success of the development of the health services in Newfoundland will depend upon the degree of integration between the University centre and the periphery.* The importance of this cannot be overemphasized [emphasis in original].”¹⁶ Reported another, “Health services for the province should radiate out from the University Hospital with other hospitals in the area using it as a referral centre.”¹⁷

Here was hierarchical regionalism writ large — yet it would be interpreted and implemented, characteristically, Newfoundland-style. The resultant landmark complex that was built on campus during the early 1970s would become known as the Health Sciences Centre (HSC), for it housed an enlarged and relocated 350-bed general hospital, the medical school, and eventually schools of pharmacy and nursing, along with satellite programs in occupational and physical therapy (based in Dalhousie University). Noteworthy is that administratively the HSC veered from what was originally envisaged as those in charge of the constituent university had nothing to do with its governance, ownership, or operation. In no way could it be considered to be a “university hospital” as typically understood elsewhere. Indeed,

even the medical school — officially the Faculty of Medicine of Memorial University — was mostly cut adrift, as it still is. Yes, on the one hand, university policies and procedures have governed students and most (but not all) instructors; tuition fees were collected by the university; and degrees are conferred by the university. Yet, on the other hand, the operating budget of the medical school (currently around \$50 million) was/is the domain of the department of health, *not* the department of education (as was/is the case for the rest of the university, and post-secondary education in general) — and money talks. Moreover, for almost all of the life of the medical school until *very* recently, all offices, laboratories, and lecture halls and classrooms were located in and run by what is now Eastern Health, and all phone numbers were connected not to the MUN exchange but to that of the hospital. Official university campus maps colour code the HSC/medical school in greyed-out tones with the legend that it is located nearby but not managed by the university, a description identical to the adjacent CBC television and radio studios and also the NSERC research facility. All of this, along with the attitude of most of the personnel employed in this environment, results in a prevailing institutional culture and *mentalité* divorced from MUN per se. In brief, by almost any measure, both historical and contemporary, the medical school/HSC is a fully integrated, major, and vital component of the NL health system, which is an arrangement dissimilar to any other comparable situation in Canada.¹⁸ Curiously, this anomalous linkage likely benefited all parties later in life as many academic medical centres/universities/university hospitals underwent disruptive upheavals as to who was responsible for what due to administrative tension over ballooning costs and conflicting priorities.¹⁹

So? The Need for and Role of History

But why does this matter? How does this apparent lengthy digression relate to the aims and content of *A Health System Profile*? One of the goals of this book was to show the distinctiveness of the health-care

system of Newfoundland and Labrador, which it addresses in several respects from quantitative and economic perspectives. However, I maintain that even from this brief overview of the origins of the province's only medical school along with its inextricable connection to NL's sole tertiary care institution, which all but guarantees the continued presence and practice of medical specialists and resident trainees (who shoulder most of the everyday — and every night — health care at the HSC), one of the most distinctive features of the jurisdiction's health-care system has been identified, one that was overlooked in *A Health System Profile*. More importantly, I believe it underscores why *any* analysis of health policy must take into account more than just the methods and paradigms of political scientists and/or health economists. It is not possible to undertake such a task without also truly offering an historical take on the subject that is not merely cosmetic. The final issue where historical thinking can profitably be brought to bear is understanding not just the organizational structure and the infrastructure of the health-care system in NL, but correspondingly its entrenched meta-constitutional makeup. Within recent history the organizational unit underpinning the health-care system has been the RHA. As already noted until 2023 there were four functioning, but before their creation in 2004 there had been 14. Pushing the clock back a bit further these RHAs, formed in the mid-1990s, resulted from the consolidation of 34 “arm's-length public boards” (29), which in turn during the 1970s and 1980s had derived from 50 independent hospital and institutional boards. Over the last half-century the pattern has been of gradual consolidation and centralization to bring about greater public accountability.

While this trend may mirror what happened in other provinces, albeit more slowly, it masks the monumental historical transformation of what were the rooted practices of health-care delivery in NL to the creation of a discernible, formal NL health-care system. For a portion of the later nineteenth and most of the twentieth century, the structure of health-care delivery might be perceived on the surface as a jerry-built, ramshackle affair where medical administrative jurisdictions were more

akin to medieval fiefdoms under the control of a physician-prince or two. In the north, including parts of the Labrador coast, the IGA reigned, with its vast network of hospitals, nursing stations, schools, stores, and hospital ships funded and staffed mostly through American philanthropy. To the east-central region was the fully modern and well-equipped Notre Dame Bay Memorial Hospital (NDBMH) built in the 1920s, which was expertly staffed by elite American doctors. In the south was St. John's with its general hospital, several religious denominational hospitals, sanatorium, and mental diseases hospital. And, beginning in the 1930s, the chain of cottage hospitals predominantly served the west coast, as well as other coastal regions. Finally, there was the network of nurses (and by today's parameters, many would be considered to be "nurse-practitioners") and licensed midwives, along with government hospital boats and other private floating clinics.²⁰

To understand this more fully, it is helpful to invoke the metaphor of an ecosystem.²¹ Health-care delivery "in the past" consisted of a series of loosely interconnected elements that functioned within their own local habitats, yet interacted with each other to their mutual advantage. The development and organization of this "ecosystem" were organic inasmuch as there was no master plan at play to oversee or guide it — what worked survived, what did not died out. Even in government circles behind the scenes, the organic pragmatism of an ecosystem was at play. The internationally recognized hospital/health-care planning consultant, G. Harvey Agnew, in his sweeping and comprehensive commissioned analysis of hospital and related facilities and personnel in Newfoundland at mid-twentieth century, described an administrative bean-counter's nightmare.²² He noted that the government public health department was all but unique across Canada as it was directly responsible for an overwhelmingly large share of all health-care delivery, and in 1951 this department accounted for 28 per cent of the province's annual budget — then, like now, the single largest expenditure. Although the department oversaw 78 per cent of the 3,335 hospital and nursing station beds, and had general figures of how much was spent in so doing, the cottage and voluntary hospitals

(i.e., IGA, the NDBMH, and religious denominational institutions) were rarely if ever actually audited over finances, despite receiving government grants). Moreover, legislation governing these facilities was enacted in 1931 (and it never was amended), which was before the Commission of Government took over, before the cottage hospitals were built, or before Confederation.

Agnew was highly complementary about the department's senior executive, Dr. Leonard A. Miller (deputy minister of health and after whom the current Dr. L.A. Miller Centre would be named²³), and Dr. James McGrath, as they were fully in touch with almost everything that was going on regarding health, but he quickly recognized that these administrators not only had an open-door policy but also that of an open house. Miller and McGrath's strength lay in their informality as almost anyone could telephone or drop in and chat with them; moreover, almost everything they did was stored in their own heads and not written down, meetings took place only as needed, and departmental policies and procedures were not codified. What Agnew encountered was a home-grown, organic, somewhat ad hoc office milieu, yet it performed well and seemed to naturally suit the decentralized, local environment in which it had to function and adapt. Again, the ecosystem metaphor seems appropriate to apply, and not that of a well-oiled bureaucratic machine.

Within the evolving environment of post-Confederation Newfoundland, the governmental administrative structure of the province became more bureaucratic and centralized with, as already noted, individual hospital boards consolidating into regionally oriented entities within a more integrated health-care system, especially as federal funds became increasingly available.²⁴ As such, the face of health care in NL became more like that of its provincial counterparts, but as the series editor makes clear in the foreword to *A Health System Profile*, there is no single Canadian health system because "provincial and territorial governments are the principal stewards for publicly financed health services in and coverage in Canada" (xiii). Yet even within the country's highly decentralized federation, especially vis-à-vis health,

he maintains that NL stands out as a “province like no other . . . [with] very unique characteristics” (xvi). The authors of *A Health System Profile* have performed yeoman service to illustrate the existing distinctiveness of health affairs due to current political and economic circumstances, but a good argument is to be made that this distinctiveness is also really deeply rooted in NL’s medical/health history.

Knowledge of this jurisdiction’s history may also help mitigate or moderate the jeremiad that is *A Health System Profile*. On the one hand, it is foolish to believe that all is good and well across the provincial medical landscape. The provincial population is apparently in extreme ill-health, perhaps the worst in Canada — seemingly an evaluation of long-standing status. People are now excessively obese, which is ironic as only a generation or two ago they were deemed to be emaciated and malnourished. The prevalence of fatal cardiovascular, respiratory, and oncogenic diseases is the highest in the country, whereas in the not too distant past it was tuberculosis that swept people off in high numbers (also the highest rates in Canada at the time). Clearly, applying any notion of “progress” seems wholly inappropriate regarding population health: *plus ça change, plus c’est la même chose*.

On the other hand, however, there is a contemporary success story to be told — and it is a story that grows naturally from a forgotten, if not consciously buried, era. Whatever may be the flaws and deficiencies of the current health-care system (and there are many of them), it is the best one that NL has likely had owing to its complement of highly specialized medical personnel, services, and technologies. Yet to claim that NL has better medical services now than it had in the past is vacuous. After all, one can argue that for about the last 150 years it has been axiomatic in medical history that the field and practice of medicine in the Western world have seen great scientific progress and technical sophistication, so the wave of medical modernity that carried the province along in its wake was ineluctable — a high tide lifts all boats. But there was an existing sound foundation within pre-Confederation Newfoundland on which modern medicine could be built better. Thomas Lodge, an English civil servant who was Commissioner for

Public Utilities in Newfoundland from 1934 to 1937, gave a positive assessment of the health-care facilities available in the capital city of St. John's: "medical organization which in its human as in its material resources need fear no comparison with that of any other city of its size in the Empire."²⁵ Although his commissioner role may cast this observation in doubt for those who rue the British-appointed form of government in this period, other analysts from outside Newfoundland brought similar perspectives to bear on their assessments of health care in the whole island.

Health policy consultant Harvey Agnew observed in his aforementioned 1952 survey for the department of health that the "*boat service* has been very helpful in getting the doctors about and in maintaining transportation facilities between nursing stations and the nearby hospitals." Furthermore, Agnew concluded that the cottage hospital system "has been of tremendous *value to the people* . . . the *qualifications of the doctors* in the service are high . . . the hospitals are quite well equipped and the *surgical results* have been excellent" (emphasis in the original).²⁶ Similarly, the *Newfoundland Health Survey Committee Report*, a requirement of Confederation, noted that around and before 1949 the vast majority of the Newfoundland population had access to primary care through a variety of schemes: government-sponsored prepaid medical and hospital care plans (cottage hospitals); voluntary prepaid hospital schemes such as that of Twillingate's NDBMH and the industrial mill company hospitals at Grand Falls, Corner Brook, and Buchans; the hospital and medical services of the IGA; and commercial insurance plans such as Blue Cross and the Maritime Hospital Services Association, whose subscribers lived primarily in St. John's.²⁷ So pervasive were most of these schemes that almost a decade and a half earlier, in 1940, United States Assistant Surgeon General R.A. Vonderlehr, a friendly invader, reported that "the provision for medical care of the people in Newfoundland at public expense is more effectively developed administratively than in any part of the United States."²⁸

Such an overall line of argument results in another intellectual

tension, in addition to the primary notion of the “Newfoundland paradox.” If one were to believe the over-the-top rhetoric of long-time premier and erstwhile godfather of Newfoundland, Joey Smallwood, then he was responsible for setting in motion actions that would result in a modern provincial health-care system. Smallwood and his ilk embedded a meta-narrative in the collective psyche that his administration was solely responsible for everything progressive in the new province, especially with health care. Smallwood’s mantra characterized pre-Confederation Newfoundland as nothing but “the dole, the dole bread, the tuberculosis and the beriberi.”²⁹ Similarly, he, along with other commentators, trumpeted how a “revolution has swept Newfoundland since confederation in 1949.” He further declared that “swift improvements in our education, health, transportation and communication facilities have set the stage for further economic growth. . . . If the progress since confederation might be counted as considerable . . . this progress will nevertheless seem puny in comparison with the growth I envisage for Newfoundland over the coming decades.”³⁰ In the same vein, MUN’s S.J. Colman invoked the concept of revolution and indicated that progress meant Newfoundlanders “no longer having to take their sick in small boats to seek medical assistance at a sometimes distant cottage hospital.”³¹ The overarching theme of inexorable progress in these commentaries was echoed in journalist A.B. Perlin’s belief in 1970 that “great modern hospitals” had sprung up in the 1950s and 1960s, which was “all very much to the good.”³² Corroborating this perspective is Frederick W. Rowe’s account of the Smallwood era; Rowe was a long-standing and trusted member in Smallwood’s cabinet. According to Rowe, “[w]hen the Smallwood era began, Newfoundland’s health and welfare programmes were deficient and primitive. When it ended they compared well with those in other parts of Canada.”³³ Yet when applied to health matters generally, this was a particularly inaccurate picture as almost anything and everything medical associated with the past was considered to be inadequate, lacking, or antiquated. In this respect, the remarks of Newfoundland journalist and satirist Ray Guy are

apposite: "After Confederation, Joey [Smallwood] and his crowd harped on it for their own aggrandizement. The world started in 1949 (according to Smallwood) — before that, there was only depravity, poverty and corruption."³⁴

It would be churlish not to grant that during the Smallwood era there was much change, but from a health-care perspective a few historical caveats and qualifications are needed to contextualize it. First is the need to underscore, as already noted, that health care in pre-Confederation NL was nowhere near as deficient and primitive as some painted it. Second, talk of the "great modern hospitals" and the claims of Smallwood and others about the later "revolution" and "improvements" in health, among other things, ought to be tempered. The case study of the West Coast Sanatorium is salutary. The official opening in June 1952 of the new Corner Brook facility for the treatment of tuberculosis was a gala affair with numerous dignitaries in attendance, but, curiously, *sans* Smallwood himself. It was touted in the local newspaper as "up-to-date and as modern an institution as there is almost anywhere in the world."³⁵ But the problem was the whole concept of a sanatorium, modern or not, was out-of-date! Across the Western world at this time sanatoria were winding down and closing beds because older methods of treatments such as rest cure (lasting years), cold fresh air, and invasive surgical operations, all of which had underpinned the *raison d'être* of the sanatorium, were being fast supplanted by more convenient and effective chemotherapy. Pharmaceuticals such as the antibiotic streptomycin (dating from the late 1940s), along with other drugs (e.g., PAS and INH), shortened treatment from years to months; and they did not need to be administered in expensive and highly-staffed institutional settings. Tellingly, months before the opening of the West Coast Sanatorium the same newspaper ran a story under the headline "Tests of New Anti-T.B. Drug Lead to Optimism," which reported how Dr. Peters, sanatorium superintendent, had travelled to the US to acquire quantities of INH for use in both St. John's and Corner Brook.³⁶

A Health System Profile: A Path Not Taken

When all is said and done there were few substantive system changes to the health-care system during the early post-Confederation era. From the 1950s to the 1970s, the cottage hospital system, the IGA empire, and fleets of floating clinics continued to do most of the heavy health-care lifting — and all continued to function in highly decentralized, localistic ways. If Smallwood et al. wanted to effect a revolution, then they might have aimed to consolidate the fragmented network that they oversaw. In not doing so, the “path dependency” that would lead to provincial health policy inertia decades later, which is well described in *A Health System Profile*, became deeply rooted. Political scientist Carolyn Hughes Tuohy crystallized thinking about path dependency and the concomitant defining role of history in policy-making in her comparative study of health-care systems in the US, Britain, and Canada during the half-century following World War II. Briefly, political decisions made or not made in the present are to a great extent dictated and/or constrained by those made or not made in the past, or expressed differently, “history matters.” In a system that is fragmented and not centrally run by the state, then typically change will likely be only incremental as there are so many negotiators to take into consideration (e.g., the US). Thus, a tradition of incremental change will predictably beget only incremental change in the present/future. In contrast, dramatic shifts in policy may be easier to implement in a more centralized system (e.g., in the UK after the formation of the NHS). As such systems have undergone major organizational transformation at some time in their history to become more centralized vis-à-vis health care, further major reforms might be easier to follow through on.³⁷

Applying the “accidental logics” of path dependency to NL is helpful to *explain* what *A Health System Profile* only *describes*. For the majority of the jurisdiction’s history (both pre- and post-Confederation), the administration of health care has been a bit of a free-for-all — the political legacy has been one of many semi-equal negotiators all bargaining on their own behalves. To reiterate, it was only beginning in

the early twenty-first century that the province really tried to fully centralize through its curtailing of the number of RHAs to four (a process that continued with the creation of one single provincial health authority as a result of implementing a recommendation of the *Health Accord*, which was also reinforced in the 2022 provincial budget).³⁸ The wisdom of such full centralization is an open question as it would put an end to the historical practice of localized health policy decision-making in NL. As there never has been any major, radical transformation of health care *pace* Smallwood, the historical pattern of reform incrementalism as lamented by the authors of the work reviewed here would not be expected to be otherwise. For my part, my main goal, however, is not just to explain the local administrative situation but also to make the case that one cannot do so fully by only deploying the skills of the political scientist or of the economist — those of the scholarly historian must also be given serious credence. As result of a close reading of *Newfoundland and Labrador: A Health System Profile*, one may reluctantly have to accept that the province is the paradoxical “sick man’ of Canada,” but even this epithet is not without its own local history.

Acknowledgement

I would like to acknowledge colleagues who read and commented on an earlier version of this essay.

Notes

- 1 <https://ihpme.utoronto.ca/research/research-centres-initiatives/nao/>.
- 2 At various times, especially when as a former associate dean of medicine for the division of community health, I had limited interaction with the first three co-authors. At no time, however, was I involved in the research, writing, or production of *A Health System Profile*.
- 3 <https://www.cbc.ca/news/canada/newfoundland-labrador/nl-cp-cyberattack-rebuilding-1.6287934>; <https://www.cbc.ca/news/canada/newfoundland-labrador/nl-cyberattack-costs-haggie-committee-1.6440817>;

- <https://www.cbc.ca/news/canada/newfoundland-labrador/nl-cyber-attack-worst-canada-1.6236210>.
- 4 On Scotland as the sick man of Europe, see http://www.gcph.co.uk/assets/0000/3606/Scottish_Mortality_in_a_European_Context_2012_v11_FINAL_bw.pdf; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3505444/pdf/ckr136.pdf>.
- 5 On Karl Ove Knausgård, see http://www.nytimes.com/2015/03/01/magazine/karl-ove-knausgaard-travels-through-america.html?_r=0; <http://www.gla.ac.uk/events/cafescientifique/events/past/scotlandthefatsickmanofeurope/>; <http://www.torontosun.com/2015/02/28/new-york-times-writer-calls-newfoundlanders-fat>; <http://www.ctvnews.ca/canada/newfoundlanders-fed-up-after-norwegian-writer-calls-them-fat-1.2260442>; <http://www.ctvnews.ca/fat-newfoundland-review-prompts-call-for-better-fitness-1.2261390>; <http://theindependent.ca/2015/03/26karls-adventures-in-newfoundland-time-for-a-healthy-debate/>.
- 6 Josh Squires, Barbara Roebbothan, Sharon Buehler, et al., "Pickled Meat Consumption and Colorectal Cancer (CRC): A Case-control Study in Newfoundland and Labrador, Canada," *Cancer Causes Control* 21 (2010): 1513–21.
- 7 "Salt Beef Junkie," written by Wayne Chaulk and recorded by Buddy Wasiname and the Other Fellers; see <http://buddywasiname.com/salt-beef-junkie-lyrics> and <https://www.youtube.com/watch?v=-72Za-dPtn3g>. Further underscoring the point is the existence of another popular group called Salt Beef Junkies; see <https://www.facebook.com/thesaltbeefjunkies/>.
- 8 Seeing is believing at <https://www.chalkerssaltmeat.com/products>.
- 9 J.D. Adamson, N. Jolliffe, H.D. Kruse, O.H. Lowry, P.E. Moore, B.S. Platt, W.H. Sebrell, J.W. Tice, F.F. Tisdall, R.M. Wilder, and P.C. Zamecnik, "Medical Survey of Nutrition in Newfoundland," *Canadian Medical Association Journal (CMAJ)* 52 (1945): 227–50. Editorial commentaries include: "Commissioner Labels Experts Report Unfair," *Daily News*, St. John's, 8 Mar. 1945, 1; "Lodges Protest with Canadian Medical Journal," *ibid.*, 1; Editorial, "The Decadent Newfoundlanders," *ibid.*, 8; The Wayfarer, "In The News," *ibid.*

- 10 C.W.R., “Your Constitution’s Down,” *Evening Telegram*, St. John’s, 16 Mar. 1945; “Your Constitution’s Down,” *CMAJ* 52 (1945): 638.
- 11 John Banville, “Review of *We Don’t Know Ourselves: A Personal History of Ireland since 1958* by Fintan O’Toole,” *Times Literary Supplement* no. 6194 (17 Dec. 2021): 3–4.
- 12 Daniel M. Fox, *Health Policies, Health Politics: The British and American Experience, 1911–1965* (Princeton, NJ: Princeton University Press, 1986), 168.
- 13 *Ibid.*, 210.
- 14 J.T.H. Connor, “One simply doesn’t arbitrate authorship of thoughts’: Socialized Medicine, ‘Medical McCarthyism,’ and Publishing *Rural Health and Medical Care* (1948),” *Journal of the History of Medicine and Allied Sciences* 72 (3) (2017): 245–71; J.T.H. Connor, “One foot on each side of the border’: Dr. Frederick Dodge Mott, Rural Health, and ‘Socialized’ Medical Care in the United States and Canada, 1930s–1970s,” in *Medicare’s Histories: Origins, Omissions, and Opportunities in Canada*, edited by Esyllt Jones, Delia Gavrus, and James Hanley, 57–78 (Winnipeg: University of Manitoba Press, 2022).
- 15 J. Arthur MacFarlane et al., *The Feasibility of a Medical School at Memorial University of Newfoundland: Report to the President, Memorial University, Newfoundland*, [1965], VIII–2; and VIII–6. A domestic medical school would also preclude the need to attract foreign-trained doctors to NL, which never actually turned out to be the case; see Taylor Dysart and David Wright, “Come By Chance: Newfoundland and Global Medical Migration, 1950–1976,” *Journal of Imperial and Commonwealth History* 49, no. 5 (2021): 994–1020; Sasha Mullally and David Wright, *Foreign Practices: Immigrant Doctors and the History of Canadian Medicare* (Montreal and Kingston: McGill-Queen’s University Press, 2020), *passim*.
- 16 Memorial University of Newfoundland, *Brief to the Government of the Province of Newfoundland and Labrador Concerning a Health Sciences Centre*, [1966], 4.
- 17 George G. Reader to J.D. Eaton, 25 Oct. 1965 in [J.R. Ellis, Association for the Study of Medical Education], *Bound miscellaneous documents by consultants to the MacFarlane Commission, 1966*, [1].

- 18 This *modus vivendi* was eagerly endorsed by the university for it allowed the duplicitous fiction to be maintained that it could be categorized as a “comprehensive” rather than a medical-doctoral university in the annual ranking of Canadian post-secondary institutions by *Maclean’s* magazine. If it had not done so, MUN would have been compared to the likes of McGill, Toronto, Western, UBC, Alberta, and so on, which would have likely seen it at the bottom of that high-powered heap. By being considered a “comprehensive” university, however, MUN typically scored around fifth place nationally in that category, which result was greatly aided by using data and metrics based on the medical school’s operation (external grants awarded, number of students and faculty, library holdings, etc.) while in effect denying its official existence! Seemingly underscoring this “nudge, nudge, wink, wink, say no more” arrangement was former MUN President Vianne Timmons’s incredulous claim that she was never informed by government officials when the latter came up with the plan in 2022 to unilaterally amalgamate the university’s undergraduate medicine, pharmacy, and nursing programs under one Faculty of Health, noting “If there were conversations, they weren’t with me”; see <https://www.cbc.ca/news/canada/newfoundland-labrador/nl-budget-2022-health-care-faculty-1.6413584>.
- 19 See Elizabeth F. Purcell, ed., *The Role of the University Teaching Hospital: An International Perspective* (New York: Josiah Macey, Jr., Foundation, 1982); Irving J. Lewis and Cecil G. Sheps, *The Sick Citadel: The American Academic Medical Center and the Public Interest* (Cambridge, MA: Gunn & Hain, 1983); Fred C. Munson and Thomas A. D’Aunno, *The University Hospital in the Academic Health Center: Finding the Right Relationship* ([Washington, DC]: Association of Academic Health Centers and the Association of American Medical Colleges, 1987).
- 20 On these, see Madeleine Mant, “Inpatients at the St. John’s General Hospital: Morbidity in Late 19th-Century Newfoundland and Labrador,” *Canadian Bulletin of Medical History* 37, no. 2 (2020): 360–94; Patricia O’Brien, *Out of Sight, Out of Mind: A History of the Waterford Hospital* (St. John’s: Breakwater Books, 1989); Gordon S. Lawson and Andrew F. Noseworthy, “Newfoundland’s Cottage

- Hospital System:1920–1970,” in Gregory P. Marchildon, ed., *Making Medicare: New Perspectives on the History of Medicare in Canada* (Toronto: University of Toronto Press, 2012), 229–48; Edward F.J. Lake, *Capturing an Era: History of the Newfoundland Cottage Hospital System* (St. John’s: Argentia Pilgrim, 2010); Jennifer J. Connor and Katherine Side, eds., *The Grenfell Medical Mission and American Support in Newfoundland and Labrador, 1890s–1940s* (Montreal and Kingston: McGill-Queen’s University Press, 2019); J.T.H. Connor, “American Aid, the International Grenfell Association, and Health Care in Newfoundland, 1920s–1930s” in Jennifer J. Connor and Side, eds., *The Grenfell Medical Mission and American Support*, 245–66; J.T.H. Connor, “... Medicine Is Here to Stay: Rural Medical Practice, Frontier Life, and Modernization in 1930s’ Newfoundland,” in *Medicine in the Remote and Rural North, 1800–2000*, edited by J.T.H. Connor and Stephan Curtis, 129–51, 260–65 (London: Routledge, 2016); J.T.H. Connor “The Notre Dame Bay Memorial Hospital, Twillingate, 1933: An Institutional Profile in a Time of Transition,” *Newfoundland and Labrador Studies* 28 (2013): 293–330; J.T.H. Connor “True Tales of Medical Adventure,” *Newfoundland and Labrador Studies* 33 (2018): 269–80; J.T.H. Connor, “Rural Medical Lives and Times,” *Newfoundland and Labrador Studies* 23 (2008): 231–43.
- 21 J.T.H. Connor, Jennifer J. Connor, Monica. G. Kidd, and Maria Mathews, “Conceptualizing Health Care in Rural and Remote Pre-Confederation Newfoundland as Ecosystem,” *Newfoundland and Labrador Studies* 30 (2015): 115–40.
- 22 Harvey Agnew, *Hospital Facilities in Newfoundland: A Study for the Honourable J.R. Chalker, Minister of Health* (Toronto: Neergaard, Agnew and Craig, 1952), <https://collections.mun.ca/digital/collection/hscbooks/id/245>.
- 23 John R. Martin, *Leonard Albert Miller: Public Servant* (Toronto: Fitzhenry & Whiteside, 1998).
- 24 Linda Kealey and Heather Molyneaux. “On the Road to Medicare: Newfoundland in the 1960s,” *Journal of Canadian Studies* 41, no. 3 (2007): 90–111.
- 25 Thomas Lodge, *Dictatorship in Newfoundland* (London: Cassell, 1939), 227.

- 26 Agnew, *Hospital Facilities in Newfoundland*, 82.
- 27 [Health Survey Committee, (Leonard Miller, chair)], *Newfoundland Health Survey Committee Report* (St. John's, [1956]), ch. 7.
- 28 R.A. Vonderlehr and R.E. Heering, *Report of a Survey on Civil Health Services as They Relate to the Health of Armed Forces in Newfoundland* (Washington, DC: United States Public Health Service, 1940), in James E. Candow, "An American Report on Newfoundland's Health Services in 1940," *Newfoundland and Labrador Studies* 5 (1989): 229.
- 29 See Robert Paine, "Smallwood: Political Strategy, and a 'Career of Rhetoric,'" *Newfoundland Studies* 3 (1987): 217–26. Smallwood's penchant for embellishing and stretching facts to the point of telling "tall tales" is explored in Paine, "The Persuasiveness of Smallwood: Rhetoric of *Cuffer* and *Scoff*, of Metonym and Metaphor," *Newfoundland Studies* 1 (1985): 57–75. For an explanation of the "dole bread" reference and its context, see J.T.H. Connor, "Malnutrition Research in Newfoundland and Labrador in the 1900s to 1930s, Brown Flour, and the 'Dole Plague' of Beriberi, Part 1: The First Malnutrition Research Wave, 1900s–1930s," *Aspects* (Newfoundland Historical Society) in *Newfoundland Quarterly* 111, no.4 (2019): 44–49; Connor, "Malnutrition Research in Newfoundland and Labrador . . . Part 2," *Aspects* (Newfoundland Historical Society) in *Newfoundland Quarterly* 112, no. 1 (2019): 48–53.
- 30 Joseph Smallwood, in R.I. McAllister, ed., *Newfoundland and Labrador: The First Fifteen Years of Confederation* (St. John's: Dicks and Company, [1965]), Foreword.
- 31 S.J. Colman, in McAllister, ed., *Newfoundland and Labrador*, 10.
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