5. Trust in God but Put Your Shoulder to the Wheel: Hospital Sisters and Modernization

Published by

McCauley, Bernadette.

For additional information about this book
https://muse.jhu.edu/book/62237
New York’s Catholic hospitals entered the twentieth century with their feet in both the old and the new world of hospital care. While general hospitals had fewer chronically ill patients than in prior decades and the number of surgical cases increased, this shift was not complete. At Holy Family Hospital in Brooklyn, the number of operations did not rise significantly until after 1913, increasing from 111 that year to 543 in 1914 and steadily increasing each year thereafter. Alcoholic patients continued to be treated in large numbers at St. Mary’s Hospital in Brooklyn. Between 1913 and 1917, St. Mary’s treated approximately five hundred patients annually for alcoholism. It was not until after 1919 that this number began to fall.¹

By then, Catholic hospital sisters were confronting a powerful reform movement in American medicine, one fueled not by any new scientific breakthroughs but rather by contemporary ideas about process and progress. Beginning in the 1890s, reformers—including physicians, philanthropists, nursing leaders, and local government officials—set about to redefine the structure and organization of American hospitals. Applying Progressive era theories of education, efficiency, and standardization to hospital care, their goal was to standardize and modernize the American general hospital: administration, architecture, patient care, and even laundry service were all targeted for reform. They were remarkably successful. By 1929, when more economic concerns took priority, many of their goals had been realized.²

Catholic hospital sisters in New York approached the reform movement with the same deliberation that had characterized their earlier efforts to open hospitals, combining religious fervor with an equally strong dose of pragmatism and conformity to mainstream medical practice. As one sister admonished in 1923, “We must not . . . expect
God to do everything and we do nothing. It will be well, I think . . . to trust in God, but put your shoulder to the wheel.”

Among the issues nursing leaders addressed was one sisters had already confronted: nursing education. As in the wake of the nursing reform movement of the nineteenth century, sisters were again under pressure to meet new professional expectations. This time, their schools, not necessarily the sisters, were the issue. Several of New York’s Catholic hospitals had opened training schools by 1910: St. Mary’s in 1889, St. Vincent’s Manhattan in 1892, St. John’s in 1900, and St. Catherine’s in 1907. By 1920, nine of the general care hospitals had nurse training programs, and all did by 1930. Hospital sisters in New York accepted most of the goals of the secular proponents of professional nursing and made adjustments and plans to conform to what nursing leaders were anxious to enact, namely more regulation and standardization in nursing education. Despite this, Catholic reaction to the rhetoric of professional nursing still sought to distinguish Catholic nurses’ training from that at other hospitals.

---

*Fig. 8. This photo from an annual report for St. John’s Hospital Long Island City illustrates something of both the old and new worlds of Catholic hospital care in the early twentieth century. Professional doctors and nurses are ready to work, but look who is overseeing what goes on. Photograph ca. 1908; Sisters of Saint Joseph, Brentwood, New York*
Like Catholic women’s colleges, the nursing schools were supported by Catholics who feared the effect of secular education and professional training on young Catholic laywomen. Agnes Copeland, supervisor at St. Catherine’s Hospital Nurses’ Training School and an active proponent for upgrading Catholic schools, explained that it was dangerous for Catholic women to attend nurses’ training courses at non-Catholic hospitals because “many of my own acquaintances have lost their religion” in such schools. In 1922, Catholic Charities of the Archdiocese of New York elaborated on the nineteenth-century Catholic position that argued that moral instruction was a fundamental part of all education: “Considering the dangers that surround a life as this, it is difficult to understand why our Catholic girls will select for training a hospital other than our own. Religious influence is an important factor in any line of education and this is particularly true in the training of a nurse in which many moral and ethical problems are involved.”

While Catholic nursing schools emphasized how they were different in this one way from other schools, it was also true that nurse training programs at all hospitals duplicated many aspects of convent life. Student nurses were almost without exception required to be single. Nursing school superintendents wanted students free from any other responsibilities or demands on their time. The students’ lives, in class and out, were precisely scheduled and monitored by superiors, much like the carefully prescribed religious life. Student nurses followed a highly supervised and rigid schedule very reminiscent of the sisters’ schedules.

At one school, for example, students attending Mass were awakened at 5:40 a.m., others at 6:15, but all were required to participate in morning prayers. “On signal at 6:40 morning prayers are held for all nurses regardless of denomination. After morning prayers all repair to the dining room and immediately after breakfast report for duty.” Until seven in the evening every hour was supervised and accounted for. Three nights a week nurses attended classes and “All lights are extinguished at ten o’clock except on Saturday and Sunday nights.”

As at other hospitals, nursing students became the backbone of the nursing staff in most of New York’s Catholic hospitals. As nursing historian Barbara Melosh notes, the student nurse “took her place in a world of female authority” where “superintendents drilled and disciplined her, constantly reminding her of her special duties,” much like the young woman entering a religious community.

The proportion of graduate nurses to pupil nurses varied among Catholic hospitals and, again, as among non-Catholic hospitals, re-
flected the size of the nursing school. In 1920, over one half of the
nurses at Misericordia Hospital and St. Vincent’s Hospital in Staten Is-
land were graduate nurses, which was unusual in American hospitals
in this period. At hospitals with larger training programs, like St. Vin-
cent’s in Manhattan, St. Catherine’s in Brooklyn, and St. Joseph’s in
Long Island City, student nurses made up a majority of the nursing
staff. 11

Hospitals had an economic incentive to open nursing schools be-
cause more student nurses meant more patients could be admitted. In
1907, for example, St. Vincent’s in Manhattan enlarged its training
school “due to the increased number of patients.” 12 As the New York
State Department of Education explained in 1912, for a hospital with
limited financial resources, “about the only hope it has of success lies
in securing a sufficient number of pupil nurses to enable it to care for
the patients at minimum expense for nurses.” 13

This national trend toward a reliance on the labor of nursing stu-
dents in hospitals was a concern to nursing reformers and a motivating
force in their ongoing quest to reorganize the system of nurse training
in the United States. The reformers wanted a greater emphasis on the
student’s education and less on their benefit to the hospital labor pool.
Seeking professional recognition and power for nurses, twentieth-
century nursing leaders directed their efforts toward expanding the cur-
rriculum and initiating state licensing of schools and graduate nurses. 14

Included in curriculum reform were guidelines requiring that a
training school provide theoretical and clinical training in five areas:
medicine, surgery, obstetrics, pediatrics, and dietetics. 15 The practical
obstetric training was problematic for many New York hospital schools
without maternity facilities but not for Catholic nursing schools.
Schools at hospitals without maternity departments used the facilities
at another hospital run by same sisters. The Sisters of Charity and the
Misericorde sisters, in particular, managed maternity hospitals, nursed
obstetrical cases, and included obstetrical training in their schools
without controversy. St. Vincent’s School of Nursing introduced ob-
stetrics in 1894—two years after opening—and students received sim-
lar training at the Sisters of Charity’s other institutions, St. Mary’s Ma-
ternity Hospital in Brooklyn and St. Ann’s Maternity in Manhattan. 16

For one group of New York sisters, however, the obstetric require-
ment presented a different kind of problem. The Franciscan Sisters of
the Poor who ran St. Francis’ and St. Peter’s hospitals were prohibited
by the rules of their community from engaging in maternity work.
Franciscan sisters therefore could not enroll in a nursing program that
included obstetric courses because this kind of work was seen as unsuitable for sisters. Similarly, as Carol Coburn and Martha Smith explain in their study of the Sisters of St. Joseph of Carondolet, early-twentieth-century nursing sisters had opponents within the Vatican who objected to their nursing male patients because they considered it unseemly for “virgins dedicated to God.”

Unlike the other sisters with hospitals in New York, the Franciscans had strong connections with a European motherhouse and, arguably, even stronger European traditions, and restrictions. In 1916, the German motherhouse in Aachen advised Cincinnati archbishop Henry Moeller, in whose jurisdiction the congregation’s American community originated, that the Franciscan sisters were forbidden to take maternity courses, and pressure to do so might make it impossible for Franciscans to continue with all hospital work. Adamant about her position, the Franciscan superior in Germany explained that “If obstetrical work is absolutely requisite in the course of training for the State examination, the Sisters shall have to restrict themselves to the care of the Poor, Aged and Incurables.” Referring specifically to a hospital in Dayton, Sister Hildegard told Moeller that “We shall rather be willing to abandon St. Elizabeth’s Hospital entirely to be transferred by Your Grace to some other community than permit the Sisters to assume charge of the maternity wards or take a course in obstetrical work.”

After Mother Hildegard visited the United States in 1922, the Franciscans changed their policy and, after that, a nurses’ training school opened at St. Peter’s Hospital in 1923. Franciscan sisters still were given firm rules regarding their own participation in obstetric cases and could only assist in emergencies. The Franciscan’s experience was unique among the New York hospital sisterhoods.

Increasingly, nursing sisters headed the nursing programs at their hospitals but the sisters initially had hired laywomen, graduates of non-Catholic training programs, to organize and run their schools. The first director at St. Vincent’s School of Nursing in Manhattan was a laywoman, Katherine Sanborne, a graduate of the New York Hospital Training School. In an unusually long term of office, she kept her position at St. Vincent’s for forty-two years. By 1930, she was the only laywoman in charge of a Catholic hospital nursing program in New York.

In most cases, sisters ultimately took over the direction of their hospital schools. After Sanborne’s retirement in 1934, Sisters of Charity ran St. Vincent’s School of Nursing in Manhattan. Some communities continued to hire laywomen, however. In 1932, the Sisters of St. Joseph
appointed one of their own members as director of St. John’s Long Island City Hospital School of Nursing, Sister Thomas Francis Cushing, but after Cushing left that post to become the general administrator of the hospital, she was replaced with a laywoman.  

At St. Catherine’s, the earliest directors were laywomen, but after 1922 Sisters of St. Dominic headed the nursing program there. One of the hospital’s early lay administrators, Nora McCarthy, left St. Catherine’s in 1914 to take over the administration of the nursing school at the Sister of St. Joseph’s hospital, St. John’s hospital in Long Island City. McCarthy was a graduate of the Sisters of Charity’s school at St. Mary’s in Brooklyn. Her career suggests how close the world of Catholic nursing was in this period and how it crossed the boundaries of religious communities.

Reform efforts also addressed the education of physicians. Some Catholics also chose to pursue this path of equal yet separate facilities with regard to physician training, but their efforts in New York were not successful. (In the nineteenth century, most physicians trained in privately operated medical schools unaffiliated with either universities or hospitals, and clinical and laboratory work was minimal. Reformers wanted to change that, and did.) New York’s only Catholic medical college, at Fordham University, opened in 1905 and closed in 1921.

The medical school was founded when the Jesuits in New York, anxious to propel their school into university status, opened a medical school and a law school. It did not do poorly in the famous Flexner survey of 1910, which rated medical schools on a model with a variety of categories and became a benchmark for the medical school reform movement. In terms of entrance requirements, Fordham’s requirements were acceptable, as was its teaching staff. Laboratory facilities were noted as “adequate for the routine of the small student body.” Clinical training was available at the nearby Fordham Hospital and Dispensary, but, contrary to Flexner recommendations, the school had no control over the hospital or the staff appointments. Fordham’s financial situation also was a problem. Flexner noted that the only monies available to the medical school were the student fees and “appropriations amounting to several thousand dollars annually from the general funds of the university.”

Overall, Fordham ranked with other schools that had yet to meet all the Flexner qualifications but were considered to be on the right track. It was not a proprietary school organized primarily to make money, one of the primary violations according to the reformers’ standards. Furthermore, unlike some schools that complained about the changes
suggested, the college responded favorably to the Flexner survey. Four
years later the school fared well in another evaluation conducted by the
American Medical Association.\textsuperscript{24}

Yet Fordham was never able to fulfill what was to become a major
reform requirement in the decade following the report—acquiring a
hospital of its own. In 1911 a physician on the medical faculty offered
his private maternity hospital to the school, and it applied to the State
Board of Charities for reincorporation as Fordham University Hospi-
tal. When it was revealed that the physician had been expelled from the
American Medical Association, the school asked that its name be re-
moved from the hospital.\textsuperscript{25}

There is no indication that Fordham ever attempted to combine
with a Catholic hospital to create the institutional complex envisioned
by reformers. To outsiders that might have seemed a likely path to pur-
sue, as all were Catholic institutions. In another very fundamental way
they were all very separate institutions. The hospitals were maintained
by religious communities, not the Roman Catholic Archdiocese of
New York or the Diocese of Brooklyn. Similarly, Fordham was not a
diocesan institution, it was owned by the Jesuit Fathers. Combining
these separate institutions was not as simple as it might have appeared
to those unfamiliar with their histories and the details of their organi-
ization and management.

Control was a critical factor in negotiations surrounding the merger
of a medical school and a hospital. As historian Kenneth Ludmerer ex-
plains, many hospital trustees opposed medical school affiliation and
many medical schools were unsuccessful finding a hospital willing to
accept the reorganization and subsequent loss of autonomy. The
Flexner report was certainly very clear about who would be in charge
in a medical school union. “Centralized administration of wards, dis-
pensary, laboratories, as organically one, requires that the school rela-
tionship be continuous and unhampered . . . The control of the hos-
pital puts another face on its relation to the clinical facility.”\textsuperscript{26} At the
same time, hospital administrators questioned the priorities of a teach-
ing hospital. Patient care did not always seem to be the chief concern
at these kinds of institutions. As Jane Addams observed, “the patient’s
comfort was ‘sacrificed to the hospitals looks.’”\textsuperscript{27}

Fordham’s finances were also a major problem. As early as 1906 the
school was operating at a deficit. Unlike the law school, cheaper to run
and fortunate enough when it was in financial trouble to find a dean
who agreed personally to meet all deficits for five years, the medical
school had no luck finding a benefactor.\textsuperscript{28} Faced with the possibility of
closing in 1919, school officials approached the Archdiocese of New York for financial help, but the new archbishop, John Cardinal Hayes, refused the request. Hayes was more concerned with the need for a Roman Catholic approach to sociology and social work than with medicine. (One of the major efforts of his early administration was to organize the various Catholic charities in the archdiocese under a diocesan umbrella.) He was also probably reluctant to finance the Fordham Medical School because the student body there was not predominantly Catholic. Statistics on the religious composition of the Fordham Medical School are not available, but clearly all the students were not Catholic. Commencement procedures even made allowances for other students—a Jewish graduate remembered that he was exempted from kissing the cardinal’s ring during the ceremony. The school’s demise suggests that the concept of Catholic superiority and expertise in the care of the sick that was so often raised in support of Catholic hospitals in the nineteenth-century did not extend to a recognition of the need for a Catholic insight or perspective on modern medical education in New York.

Another reform emphasis involved efforts to upgrade (in the reform language) the requirements necessary for hospital administrators. This had always been a position that sisters in Catholic hospitals held. Some hospital reformers argued that the duties of a hospital administrator were more complicated than in the past and, as a result, required special training. They claimed that because acute care translated into a greater turnover in patient population, because technological changes and growth made for a more complex physical structure, and because rising costs demanded a more elaborate financial structure, hospital administrators needed special skills and experience in administration.

The argument undermined the traditional characterization of the job as one requiring feminine qualities. Some reformers considered the sisters to be unsuitable administrators by simple reason of who they were. A survey conducted by the Brooklyn Diocese of Catholic hospitals in Brooklyn and Queens in 1923, for example, noted with disapproval that the superintendent at St. Joseph’s Hospital in Far Rockaway was not sufficiently trained for hospital administration. She was not a nurse and although she had executive experience in schools, until her appointment to St. Joseph’s she had never worked in a hospital.

The emphasis on formal education for hospital administrators remained more talk than action, however, in both the secular and Catholic hospital world, although specialized training was available.
through individual courses, often in postgraduate nursing education. In New York, the graduate program in nursing at Columbia University included a course in hospital administration. A sister from St. Mary’s Hospital in Rochester, Minnesota, (associated with the Mayo Brothers clinic) who attended this program in the early 1920s encouraged other sisters to attend, but she pointed out the difficulties as well. She noted that courses and field work were excellent and that daily contact with all different people, especially nonreligious, was “broadening,” but she also complained that it was physically difficult for sisters to attend Columbia. Accommodations were limited, and sisters missed their community life. For the time being, graduate work in hospital administration remained an ideal rather than a necessity.

When they could, New York’s Catholic hospital sisters conformed to the administrative and organizational aspects of the reform movement. Sister Marie Immaculate Conception of Misericordia Hospital supported a new criteria to choose hospital supervisors, explaining how the “sister-nurse, carefully and efficiently trained as she may be, is not yet prepared to fit into the various executive positions of the hospital. She may be an excellent nurse, unsurpassed in the care of her patients; yet as a supervisor, as a superintendent, she may be a complete failure.” Included in the accomplishments profiled in *Hospital Progress*, the journal of the Catholic Hospital Association founded in 1916 by the Sisters of St. Joseph of Carondolet, Wisconsin, and Rev. Charles B. Moulinier, S.J., of the medical college of Marquette University to encourage reform among hospital sisters, were examples of New York success stories. St. Catherine’s in Brooklyn, for example, boasted of its accommodations to standardization with extensively detailed reports from staff members: Sister Ildephonse reported on “The Record Room,” Dr. DeCoste on “Pathology and X-Ray Labs,” and Dr. Gordon on “Obstetrics in St. Catherine’s Hospital.” Other articles about New York’s hospitals reflected the long reach of reform. St. John’s in Long Island City was cited for its social service department and new nurses’ residence, Mary Immaculate in Jamaica for its fire prevention.

The greatest concern to sisters was the cost of reform. Hospitals had different support networks and some were able to spend more than others. Commenting on the high cost of modernization in 1922, Catholic Charities of the Archdiocese of New York noted that while St. Vincent’s in New York was able to spend “$161,000.00 on the improvement of its plant and in scientific equipment . . . Other hospitals in need of improvement were not as well able to meet the financial burden.”

80
Also contributing to financial problems was the fact that many patients did not pay for their total care at Catholic hospitals. That had always been the case, but part of what made Catholic hospitals different from other hospitals was that some patients did pay at least something toward their care. Now patient payments were expected at almost all hospitals and (fundraising appeals from Catholic hospitals frequently noted the number of non-paying patients. At St. Vincent’s in 1925, for example, 22 percent of patients were treated free of charge and 26 percent made partial payment. Such was the case at other Catholic hospitals as well. That same year Catholic Charities of New York found that 23 percent of all patients treated at Catholic hospitals in the New York Archdiocese were treated free of charge and 28 percent made partial payment. Another 10 percent were public charges. While the hospitals received reimbursement from the city for these patients, according to Catholic Charities, the reimbursement did not cover the actual costs of care. 37

In the Brooklyn Diocese some Catholic hospitals treated a greater percentage of free patients than others, again an indication of the distinctions between Catholic hospitals. In 1922 almost all patients at St. Joseph’s Hospital paid for their care (94%), yet over one-half of the cases treated at St. Peter’s were free patients. The other hospitals in the Brooklyn Diocese all had over 50 percent paying patients: Mary Immaculate, 76 percent; St. Catherine’s, 69 percent; St. John’s, 68 percent; St. Mary’s, 66 percent; Holy Family, 64 percent. City charity cases were highest at Holy Family (29%) and St. John’s (19%), while St. Peter’s did not have any. 38

Financial restrictions limited the extent to which sisters could upgrade to meet reform standards. In 1921 the Sisters of Charity sold their newest hospital, St. Lawrence, because it needed improvements that the Sisters of Charity could not afford. Concluding that the community needed an expanded facility as soon as possible, they sold it to the Missionary Sisters of the Sacred Heart, who promised to develop it immediately. The proceeds from the sale of St. Lawrence were disbursed among other institutions the Sisters of Charity owned, including St. Vincent’s in Manhattan. Facing similar circumstances, when the Sisters of St. Dominic made plans to expand and upgrade Mary Immaculate Hospital, they transferred the ownership of the property to the Diocese of Brooklyn and converted the corporation to a diocesan hospital. In doing so the hospital became eligible for increased diocesan financial assistance. 39

Fundraising continued to be a major concern of Catholic hospitals
in the 1920s. Fundraising efforts at Mary Immaculate in Queens and St. Vincent’s in Manhattan, both involved in major rebuilding in the 1920s, reveal how reform methods extended to fundraising and that Catholic hospitals recognized a need to extend their reach in this new era. At Mary Immaculate, businessmen were brought in to direct the appeal, and two years before the campaign actually began a press agent was hired to publicize the hospital and prepare the community for the need to contribute. The plan was to canvass forty thousand families whose names and addresses had been garnered from church membership rolls, telephone books, and the motor vehicle department. An instruction manual with pertinent information and tactics “made efficient salesmen and saleswomen of the workers” who numbered over 1,500, referred to as an “army” by the chairman of the organizing committee. The appeal was highly publicized: print and radio ads, flyers, posters, mailings, and an essay contest in parochial and public schools “so that all the children . . . might be interested in the work and in turn interest their parents.”

The campaign was delayed until an appeal at the nearby Jamaica Hospital had concluded, indicating that the fundraisers recognized that theirs was not a Catholic project exclusively. The campaign emphasized that Mary Immaculate was a hospital serving the entire community. Although the appeal was organized through local Queens parishes, non-Catholics were recruited as workers and for supervisory positions. Unlike nineteenth-century fundraising, which emphasized the need for the continued charity of financial supporters, the theme of this campaign was the community’s responsibility for its hospital. Mary Immaculate was characterized not as a charitable institution but as a community service for all citizens on par with the fire department or the police. Campaign literature noted that “The average person will need a hospital 75 times oftener than he will need a fire engine.”

Like efforts at Mary Immaculate, St. Vincent’s appeal for funds in 1926 was highly organized and directed toward a wide audience. New York mayor Jimmy Walker, once a patient at St. Vincent’s, was just one of the donors profiled in a campaign organized to raise funds “to increase its accident and emergency facilities, to provide more treatment rooms for all kinds of cases, to provide five times its present number of beds for children, to provide a maternity department, to pay for the nurses’ home now under construction, to enlarge the laboratory, to accommodate more interns, and to supply much-needed x-ray equipment.” St. Vincent’s appeal was also traditional in tone and stressed the unreimbursed patient care the hospital delivered, as well as citing ris-
ing expenses due to modernization. Fundraising literature reminded would-be donors that “in modern society one is unable to render personal service to the sick and needy as the Good Samaritan did, but that institutions like St. Vincent’s Hospital can perform the service if the would-be Good Samaritan will supply the means.”

Throughout this period, sisters continued to be ultimately responsible for the financial maintenance of their hospitals. Although health divisions were included in the Catholic Charity organizations of both the Archdiocese of New York and the Diocese of Brooklyn, the purpose of these departments was advisory and they were in no way meant to assume financial obligation on the part of the hierarchy for hospital or patient costs. Catholic Charities of the Archdiocese of New York made that very clear in its annual report of 1925, which explained that the “Central Organization [of Catholic Charities] never assumes financial responsibility for the care of any patient in one of our own Hospitals, although we do refer many cases for treatment.”

Catholic Charities’ interest was in maintaining standards. The same report made clear that each hospital was required to make some provision for the care of the poor, but it emphasized that its financial assistance to a hospital was “granted when it is needed in order to maintain high standards of efficiency, rather than in consideration of the number of charitable cases it receives.” Catholic Charities promised that if the hospitals provided care and treatment to the free as well as the pay patients the organization referred, the Archdiocese would “help it meet the requirements which modern standards demand.”

Even with those qualifications, that financial assistance was limited. Between 1920 and 1930, Catholic Charities of the Archdiocese of New York only allocated a small percentage of its total appropriations to hospitals. There were several initial appropriations to general hospitals, including ten thousand dollars to St. Vincent’s Manhattan and twenty-five thousand to St. Vincent’s in Staten Island, and funds allocated to health-related institutions and organizations totaled almost one-third of the money spent between 1920 and 1921. However, after that initial expenditure, Health Division appropriations amounted to less than 10 percent of the Catholic Charities’ annual total. Furthermore, allotments in the Health Division were usually for chronic rather than acute care institutions. Convalescent homes, visiting nurse services, mental health, and social service organizations, as well as institutions for the aged and chronic patients, were more likely to receive assistance than hospitals.

The directors of Catholic Charities felt their money was better spent
in a chronic rather than acute care hospital. Noting that general hospital care was primarily acute care now, the diocese maintained that it was no longer necessary to provide that care in a Catholic environment. Catholic Charities argued that it was impossible to care for all Catholic patients in a Catholic hospital (pointing out that it was often more convenient for a patient to attend a non-Catholic institution) and concluded that “in individual cases, however, there is reason for insisting on care in one of our own institutions . . . In particular this is true in the cases of Tuberculosis and Cancer. These patients must of necessity spend a long time in the hospital; for them the spiritual comforts and consolations of the Catholic hospitals mean much.”

Maternity patients were also a special concern to Catholic Charities, which noted that “it is often highly desirable and many times absolutely necessary that they be cared for in our own hospitals. In these days of Birth Control propaganda we must have adequate accommodations in Catholic Maternity hospitals not only for the poor but for persons of moderate means.”

By 1930, much of the old rhetoric used to describe Catholic hospitals was no longer appropriate. One hospital superior expressed concern over continued reference to her institution as a “free public hospital.” Her lawyer reassured her that some charity patients were enough to satisfy the corporate definition, noting she “need have no qualms of conscience about characterizing the institution as a free public hospital. [T]he receipt of money from patients who can pay does not in any way detract from the status of a hospital as a free institution if the main purpose of the hospital is charitable, and if this is not a money making institution.”

Other points, particularly those that originally had been raised to justify the need for specifically Catholic hospitals, were less easily addressed. The nineteenth-century hierarchy, for example, spoke of the need for Catholic hospitals because they worried about the availability of Catholic services and religious ritual to patients in public and other private hospitals. That was certainly no longer a problem in twentieth-century New York. As Catholic Charities in the New York Archdiocese explained in 1928, “the priest and any other minister of religion is given every courtesy in most hospitals.”

A twentieth-century characterization of the hospital as a community institution geographically defined, made older arguments surrounding the need for Catholic hospitals irrelevant. A Brooklyn diocesan survey found in 1922 that at most hospitals a majority of patients remained at least nominally Roman Catholic but a significant number of patients
were not Catholic. At St. Catherine’s, St. Mary’s, and Mary Immaculate, at least one-third of patients specified their religion as either Protestant or Jewish. St. Joseph’s Hospital in Far Rockaway had an exceptionally high non-Catholic population. While one-half of the patients at St. Joseph’s were Catholic, Protestant, and Jewish patients each accounted for one-quarter. St. Joseph’s appeal letter in 1926 was sent to all clerics in the area—Catholic, Protestant, and Jewish.\(^{50}\)

By the same token, a number of New York City private hospitals that were not Catholic institutions treated a large amount of Catholic patients. Roman Catholics accounted for over one-half of the patients treated at Knickerbocker Hospital and the New York Hospital in 1925. In Brooklyn, 45 percent of the patients treated at Brooklyn Hospital were Roman Catholic, and over a third at Wyckoff Heights and Norwegian Lutheran.\(^{51}\)

Many patients appeared to be choosing a hospital based on its location rather than its religious affiliation. St. Vincent’s still attracted patients from all over the city, so religion continued to be an operative factor in patients’ choice there, but at least half the patients in other Catholic hospitals in Brooklyn and Queens lived in the area surrounding the hospital: over 70 percent at Holy Family, St. Catherine’s, St. John’s, and St. Mary’s, and 80 percent at Mary Immaculate. The large Catholic populations reflected a location with a high percentage of Catholic residents, not necessarily the patients’ choice to be treated in a Catholic institution. St. Joseph’s larger percentage (40 percent) from outside the borough reflects the hospital’s location on the border of New York City—areas nearby St. Joseph’s included towns in Nassau County.\(^{52}\)

These changes complicated attempts to delineate a uniquely Catholic responsibility in health care. A priest reminded the International Guild of Catholic Nurses in 1924 that a Catholic nurse should know how to assist a patient to make a perfect act of contrition. But he also acknowledged the difficulty of the task if in fact “the patient has never had the faith.”\(^{53}\)

As the Great Depression worsened, all of New York’s hospitals, including the Catholic ones, suffered a loss in patient revenue. The number of ward patients rose, and private rooms, the source of the greatest potential revenue, went unused. A survey conducted in 1933 found that among all nonprofit hospitals in New York, ward occupancy ran at 81 percent, semiprivate rooms at 55 percent, and private rooms at 35 percent. As Rosemary Stevens explains, hospitals were once again increasingly charity institutions but now served a much broader section
of the population. Patients who might have been able to pay for hospital care in the 1920s no longer could; even fewer patients could pay for their total care or make partial payment. In 1931, 35 percent of patients treated at Catholic hospitals in the New York Archdiocese paid for their care, 24 percent were treated free of charge, 16 percent made partial payment, and 23 percent were welfare cases.54

New York’s Catholic hospitals were not alone in their financial problems: the cost of expansion and upgrading was nondenominational, and now the cost of modernization loomed alongside new financial concerns. With the onset of the Great Depression, all American hospitals faced a new and severe economic crisis. Amid that, Catholic hospitals faced an additional crisis of definition.