Who Shall Take Care of Our Sick?

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In the decades following the standardization movement, an alternative model of hospital care was no longer anything to boast about. Hospitals needed to show the public that they were up-to-date, not different. Moreover, Catholics no longer faced discrimination at other hospitals. As the annual report of Catholic Charities of the Archdiocese of New York noted in 1928, “the priest and any other minister of religion is given every courtesy in most hospitals.” The same report explained that a “majority of patients are satisfied with a hospital in which they can receive adequate care for their physical ailments,” suggesting some concern within the church hierarchy that a hospital’s religious affiliation was no longer of great concern to patients.1 As a result, Catholic hospital promoters began to characterize Catholic hospitals in a new way, as community institutions and stressing geography rather than religion or ethnicity.

Did Catholic hospitals cease to be distinctive in the early twentieth century and beyond? In one respect they did. Through the 1960s most Catholic hospitals continued to be run by the same communities of women religious that had founded them, and sisters remained in hospital work in a number of ways. They still nursed (even as paid nurses became more commonplace and outnumbered nursing students as staff in the period following World War II); they worked as nursing teachers, pharmacists, x-ray technicians, and the like; and they continued as administrators and as members of hospital boards of trustees. As women, and religious women at that, they were an anomaly among other hospital executives. Photographs show hospital sisters in their traditional habits alongside laymen and women in modern dress and even with other hospital personnel in lab coats or nurses’ uniforms, looking like as if they had landed from another world. In some ways they had.
For these women, their mission was the same as it had been when they began. As they went about their hospital work, sisters had more on their minds than physically attending to illness. For them, hospitals were part of a wide-ranging agenda, one that included a multitude of other work. Sisters’ definition of their mission of charity went far beyond financial matters; their responsibility was to those in need physically and spiritually. For sisters, hospital care was by definition a part of their charitable mission and neither payment nor “modernization” had anything to do with that.

While sisters remained constant in their mission, what did change was the fundamental characterization of Catholic hospitals as sisters’ hospitals. Catholic hospital boosters no longer emphasized that their institutions were distinct because the sisters brought something special and superior. No longer did a Sister of Charity’s description of her
community’s involvement at Holy Family Hospital as fundamentally a history of “a service so dear to us” count as the most critical factor in defining superior hospital care.\(^2\)

Like Catholic hospital development in the nineteenth century, the history of Catholic hospitals in the twentieth century parallels some major national trends—it is a story of hospital closings and mergers, not new foundations. The year 1965 marked the beginning of a decline in the number of American hospitals, particularly in urban areas, and the greatest proportion of hospital closings were among the private, not-for-profit institutions. Between 1965 and 1975, the number of Catholic hospitals nationally fell from 803 to 671.\(^3\) In New York, some hospitals closed; in other instances founding communities withdrew and ceded ownership and control to Diocesan authorities, and some hospitals were merged into Diocesan organizations. St. Vincent’s in Manhattan, the city’s very first Catholic hospital, was reorganized in the 1980s under the joint sponsorship of the Sisters of Charity and the Archdiocese of New York. In 1990, for the first time in its 140 year history, the director of St. Vincent’s Hospital was not a Sister of Charity.\(^4\)

A frequently cited explanation for these changes in Catholic health care is an enormous decline in the numbers of Catholic women religious. As with most assumptions about sisters, it is only partially true. The number of sisters did drop dramatically in the last quarter of the twentieth century, as fewer women joined religious orders and many professed sisters left their religious communities.\(^5\) Most of the reorganization of New York’s Catholic hospitals was simultaneous with this change, but the roots of it are deeper and located in the early twentieth century. The circumstances surrounding the Sisters of Charity’s departure from two hospitals in Brooklyn, in 1941 and in 1955—decades before the lessening number of sisters—suggest that there is more to the story than a shortage of nuns.

The first hospital the New York Sisters of Charity left was St. Mary’s in Brooklyn. As at other Catholic hospitals, the hierarchy’s role in the management of St. Mary’s was originally minimal. Catholic Charities made recommendations about modernization and standardization, but its role was advisory.\(^6\) When they left St. Mary’s, the sisters explained their departure as a result of the pressures of reform and changing expectations. Specifically, the need for increased education for the sisters inhibited their ability to function effectively. Their departure from St. Mary’s was ostensibly necessary and agreed on by all, and they continued with their other hospital work in Brooklyn at Holy Family Hospital. The story as they presented it made some sense. The hospi-
tal was in weak financial condition, the result of the lingering costs of standardization coupled with the stress of a decade-long economic depression.7

Furthermore, St. Mary’s had always had more of a diocesan connection than other hospitals. It was founded on the bishop’s directive with the proceeds of a diocesan fair. The first president of the board of trustees of the hospital was Bishop John Loughlin, and all consecutive bishops of the Diocese of Brooklyn continued to hold that position. By 1940, only one Sister of Charity remained on the board. In a letter from the board of trustees to the Sisters of Charity on their departure, Vice President Edward Hoar referred to the community’s “association” with the hospital, noting that they had been “in charge” for fifty-eight years. There was no sense that this hospital belonged to the Sisters of Charity in any way.8

A very different set of circumstances surrounded the community’s departure from Holy Family Hospital in 1955. The Sisters of Charity left Holy Family only after unsuccessfully resisting diocesan plans. The controversy between the sisters and the hierarchy began in 1955, when

*Fig. 10.* Sister Loretto Bernard Beagan, S.C., was a nurse at Saint Vincent’s Hospital in Manhattan from 1926 to 1936. She returned as administrator in 1948 and left in 1960 to assume the position of mother general of the Sisters of Charity of New York. Photograph ca. 1960; Sisters of Charity of New York
the Division of Health and Hospitals of Catholic Charities of the Diocese of Brooklyn expressed a desire to merge Holy Family with the nearby St. Charles Orthopedic Hospital, which was run by the Daughters of Wisdom. Catholic Charities’ plan was framed around the premise that this merger would maximize resources. They concluded that recent medical advancements in polio treatment and rehabilitation lessened the need for St. Charles, a children’s orthopedic hospital, and they intended to erect one larger general hospital on the site of Holy Family Hospital. The Sisters of Charity were asked to assume control of the merged institutions.9

Advised by the diocese of its plan, the governing board of Sisters of Charity met at their motherhouse and decided that they would not be able to assume responsibility for a larger institution and that they preferred to leave matters the way they stood. The diocese would not take no for an answer and continued to pursue the merger. The future of the plan came to rest on the question of who owned the hospital and could decide its future. Did the Sisters of Charity own Holy Family or did the Diocese of Brooklyn?10

The Sisters of Charity thought they did but were advised by the diocese to recheck their records. Upon doing so, they found that earlier in the century this same question of ownership of Holy Family Hospital had been raised but toward a different purpose. In 1925, anxious to receive diocesan endorsement of loans much needed to finance building and renovation (they were in danger of losing their nursing school accreditation), the Sisters of Charity sought to assure the hierarchy that they had no claims on ownership. Mother Vincentia wrote the bishop that although “the incorporators at the request of the late Bishop McDonnell were Sisters of Charity, and they have since 1909 continued to act as managers and trustees, they have never regarded the institution otherwise than as a diocesan hospital and wish in all things, to carry out the intentions of the Bishop and his consultors in their management of the Hospital.” While it may have appeared that “the Hospital of the Holy Family is a Community owned hospital,” that was not so.11

The matter did not end there; two years later the question was still being pursued. In February 1927, the Sisters of Charity were advised that the bishop wished to “establish beyond a doubt, the claim of the diocese to the property, before assuming liability for a large loan for building purposes.” To facilitate these arrangements, the bishop insisted that “all papers indicating that the Hospital of the Holy Family is a Diocesan Institution be sent to the Diocesan Attorney . . . all deeds for properties recently purchased with Diocesan funds be also for-
warded . . . and hereafter any property that might be bought or any business that might be transacted by means of Diocesan funds and all legal business pertaining thereto, will be settled by [our] Diocesan Attorney.” The sisters complied.¹²

Reviewing all these transactions in 1955, the Sisters of Charity had to conclude that the Diocese held the trump card. Agreeing that they were unable to staff an enlarged hospital, their council discussed other options and decided that they would withdraw from Holy Family rather than have it be said that they were forced to leave. When the Diocese of Brooklyn failed to respond to one final assertion of their position on the matter, they announced their willingness to leave at the bishop’s convenience. They did so in November.¹³

The paper trail leading to the diocese’s ultimate direction of the future of Holy Family Hospital illustrates the constant financial burdens of hospital reform, circumstances certainly not unique to Catholic hospitals. In 1955, the hospital was in desperate need of renovations, and the sisters themselves saw the circumstances as critical. At a general meeting of the community’s advisory council, Sister Loretto Bernard, superior at St. Vincent’s Hospital, advised the other Council members that “she would not be in favor of remaining [at Holy Family] unless we could improve the quality of care given by the hospital . . . it is not bringing credit on our community or the Diocese of Brooklyn. Accreditation has been withdrawn, there are long lists of violations which could be eliminated only with great effort and vast organization and physical improvements.”¹⁴

While the Sisters of Charity recognized that problems existed and that they were grave ones, not all saw the diocesan plan as the only solution. As her earlier comment indicates, Loretto Bernard was concerned with the level and quality of care at Holy Family, but she suggested another alternative. She recommended coordinating “all community hospital work with the direct supervision of major superiors, to see that standards are conformed to.”¹⁵

These events, and to a lesser extent the earlier ones at St. Mary’s, occurred before the enormous decline in the number of women in religious orders, which began in the late 1960s. The post–World War II years saw tremendous enrollment for most female religious orders. In 1951, eighty-three women entered the Sisters of St. Dominic’s Novitiate, double the usual number. Among the Sisters of Charity, where entrance numbers had been on a slow decline since the 1920s, there was also an upsurge in membership.¹⁶

Like others throughout the country, New York communities enthui-
siastically readied themselves for all the real and anticipated recruits. The Dominicans modernized and expanded their Motherhouse and Novitiate in Amityville, Long Island; the Sisters of St. Joseph did the same at their properties in Brentwood. Both facilities resembled one described by a sister from another community. “The building was huge. Three wings stretched out from the central section, which contained the main entrance, the chapel, and the visiting parlor. One wing was for the professed sisters, one for the postulants, and one for the novices . . . The grounds seemed endless, green and rolling.”\textsuperscript{17} Their expansion and optimism was part of worldwide sentiment. In the early 1960s, it seemed to many observers in and outside the church that the time had come for a different kind of Catholicism, one more open and active and less authoritative. Pope John XXIII’s Vatican Council, which ended in 1965, heralded the way for change.\textsuperscript{18}

An important part of the council’s message was that there needed to be a larger role for the laity, both male and female, in church activities, but this message was in no way intended to diminish the need for female religious orders. In fact, just the reverse was expected: many sisters and would-be sisters hoped to see that role expanded. Statistics show many women beginning to leave the convent after 1963, but at the same time, many young Catholic women were optimistic about change in their church and, as a result, they continued to enter religious communities.\textsuperscript{19} As one former sister who entered a religious order in 1967 recalls, “When I entered the convent it was not as archaic a decision as it might now seem. Convents all over the country were expanding. The tide would very soon begin to run the other way, but in 1966 there were 181,421 nuns in the United States, the most there would ever be. Change was in the air—positive change—and the Catholic Church was part of it.”\textsuperscript{20}

When reforms were not forthcoming, fewer women entered while more sisters left, and overall numbers declined rapidly. The reevaluation of Catholic attitudes about who was most qualified to run hospitals began before the religious communities felt the numbers crunch, however. At St. Mary’s and Holy Family, founding sisters left hospitals for reasons not related to a decline in the number of sisters. An emphasis on the sisters’ numbers—or lack of them—perpetuates the idea that Catholic hospitals survived and succeeded primarily because of the cheap labor of the sisters. That sisters did not receive wages in the nineteenth century was not the pivotal factor in their success. New York’s Catholic hospitals succeeded because of the way they did their work and attracted patients and financial supporters.
The declining emphasis on sisters as delineators of Catholic hospital distinctiveness in the early twentieth century was concurrent with a change in attitudes within the church about the role and capability of sisters. A codification of canon law in 1918 tightened regulations for sisters and emphasized the separation of their lives from the rest of the world even for communities actively engaged in work outside of their convents. Referring to this “cloistered mentality,” Mary Ewens explains how after 1920, “sisters were warned to restrict contact with the outside world as much as possible. Newspapers, radios, libraries and so on, were seen as dangerous distractions, as were various kinds of public events and meetings.”

It is not difficult to see how a new perception about the proper role and behavior for sisters would influence attitudes about their capabilities. Apparent in the pattern of events at Holy Family is an implication that the sisters were naive about the real world of hospital management. Catholic Charities applied for the approval of the Hospital Council of Greater New York even before presenting their plan to merge Holy Family with another hospital to the Sisters of Charity. The Sisters of Charity were never asked to participate in the decision-making process—they were given the choice to be part of the new venture (at great cost to their community) or not. Some sisters had a less deferential view of their relationship with the hierarchy. Writing to her bishop in 1925, a superior at Holy Family noted that while “Our intention and desire in the management of the hospital, and our interest in it, have never been other than to serve the Diocese . . . if there is a legal question to be decided we would like to be consulted and represented.”

In the context of these changes, some Catholic hospital supporters looked to characterize the Catholic physician as the meaningful factor that distinguished Catholic hospital care from other hospital care. This took some doing since most physicians at Catholic hospitals did not receive any special Catholic medical training. Unlike the numerous Catholic nursing schools, there were relatively few Catholic medical schools and, after Fordham University closed its school of medicine in 1921, none in the New York area until Seton Hall in New Jersey opened a medical college in 1956.

In the 1950s, the Association of Catholic Physicians, a group first organized in 1931, revived an early-twentieth-century point of view, articulated by Rev. Thomas Conaty, rector at Catholic University, about the need for a specifically Catholic medical education to foster Catholic principles and ethics. The association’s journal, *The Linacre*, included
frequent articles discussing the appropriate training for the Catholic doctor. The dean of the Creighton University School of Medicine in Minnesota, for example, explained the need for Catholic physicians in light of “our present day civilization, with its rank materialism and utter disregard of all things spiritual.” In addition to his clinical responsibilities, the Catholic physician, especially the general practitioner, had another “heavy burden” because of his “special role as family doctor and counselor.” As a result, “Next to the parish priest the family doctor should gain and hold the confidence of the members of his community. His mode of living and moral standards must be of the highest if he is to keep faith with the trust they place in him.” The editorial concluded by noting that the training for this tremendous responsibility was best found in a Catholic medical school.24

Such writings likened becoming a Catholic physician to a religious experience as much as a medical one, and they echo earlier remarks about sisters and health care. Nineteenth-century Catholics claimed their hospitals were different because the sisters were religious women and, as such, cared in a special way about their patients. However, physicians were secular men—possibly anxious to bring another level to their clinical work—but very much unlike the sisters whose entire life was organized around religious concerns. Furthermore, not all physicians in Catholic hospitals were Roman Catholics; it was not a requirement for staff positions. Ultimately, Catholic physicians would not distinguish Catholic hospitals the same way the sisters had.25

Sisters were never mentioned in this discussion of Catholic doctors because they were never physicians in Catholic hospitals. None of the communities involved in hospital work in New York had ever trained any of their sisters to do so. To begin with, sisters would have faced extreme difficulties pursuing medical education. Although some medical schools began to open to women students in the nineteenth century, the twentieth-century hospital reform movement closed many of the few schools traditionally available to women. Although official papal permission was granted in 1936 for sisters to study medicine, few did. In New York, Catholic sisters were always nurses not doctors. Meeting nursing educational requirements was relatively simple for sisters. Nurses’ training, did not challenge any time-held sisterly traditions, was inexpensive compared with the cost of physician education, and was conducted within the sisters’ own world, initially in hospitals and, later, at sisters’ colleges.26

Sisters continued to work and manage Catholic hospitals in New York after modernization, but they were no longer seen as the experts.
in hospital care exclusively by nature of their lives and identification as religious women. Now sisters worked in their hospitals as trained professionals: as nurses, administrators, in labs. They remained religious women, and, for all that otherworldliness some of their critics found troublesome, New York’s hospital sisters had accomplished quite a bit.

Their hospitals that remain are a quiet reminder of a different time for New York Catholics and their church. Sisters were not necessarily saints, or even ahead of their times in matters like class and race which we now recognize as inherently linked to issues of health care and social welfare. While they promised equal care to all, sisters were really only concerned with taking care of “their own.” That they did, and their efforts had repercussions for both the city and the church.

Hospital sisters had eased the burdens of illness for several generations of immigrant New Yorkers and left the Catholic Church firmly entrenched in the hospital landscape of New York City. They did so as religious women cohabiting their Godly world and immigrant New York; in fact, they integrated the two easily.

Sisters’ faith in the omniscient power of God included their belief, and no doubt many times their hope, that He would heal the sick in their care. Nevertheless, theirs was not a treatment infused with a zealot’s dramatic display of religiosity but one that recognized that good health care was more than medicine and surgery. At the same time, the therapeutics of their health care was decidedly noncontroversial and up to date scientifically.

The history of what sisters did in their hospitals in New York City counters some powerful perceptions about nuns which have seeped into our popular culture—contradictory images of menacing psychotics and passive church mice. That history tells a different story, one of determined and pragmatic women who, in choosing an alternative lifestyle for themselves, also embraced the world around them.