Catholic Sisters in the Hospital Marketplace:

THE GENESIS

Went on board of hospital boat 'Red Rover' for the first time with a message to our captain. Saw some of our wounded and sick. All seemed to be doing well. Found that some ‘Sisters of Charity’ were stationed on the boat and all the patients spoke very high of their patience and self-denial.\(^1\)

John Gordon Morrison
July 20, 1862

In 1862, John Gordon Morrison, an Irish immigrant serving with the Thirtieth New York Volunteer Infantry, had been assigned to the USS *Carondelet* in the western theater of the war when, following an engagement with the Confederate ship *Arkansas* on the Mississippi River, he “put the last shot in her.” Several of the sick and wounded from that battle were taken to the USS *Red Rover*, the navy’s first hospital ship. After his visit to the ship, Morrison recorded the above note in his diary. The nuns he encountered actually were the Sisters of the Holy Cross, and they were among over five hundred Roman Catholic nuns from twenty-one different religious communities who served as nurses during the Civil War\(^2\) (see fig. 1.1).

Historically, Catholic sister-nurses have had a mission to care for the sick, the injured, the aged, and the dying. In the competition for hospital
services in the United States, they were around from the start. They adopted an economically based model that was established upon finding and servicing markets of consumers. One way of understanding their entrepreneurial roles, then, is that they went where Catholics and potential Catholics congregated and provided services for these specific groups.

**Social and Medical Needs and the Hospital Marketplace**

New medical markets developed in the nineteenth century as immigration brought diverse cultures and religions that crowded the East, Midwest, and West. “Push” factors in Europe such as famine and religious persecution and “pull” factors in the United States such as available jobs and land increased the number of immigrants and more than doubled the total number of Catholics by 1860. Between 1820 and 1840, over 260,000 Irish
came to the United States. Fueled by the Great Famine that struck Ireland in 1846 to 1851, which resulted in the deaths of nearly two million people, over one million Irish left their country. Germans were the other Catholic immigrant group that settled in the United States before 1860, numbering approximately 1.5 million people. Even larger increases in immigration occurred after 1890 when other groups emigrated from southern and eastern Europe. Medical markets also increased in response to the need for services by people congregating in urban, mining, and railroad centers who were detached from traditional family-based medical care. These problems intensified in the Midwest, Texas, and Utah as railway and mining centers increasingly attracted single, primarily immigrant, men who had nowhere to turn when they became ill except to a hospital.

Catholic leaders worried over losing immigrants to rival social and religious enticements. Urbanization and industrialization had generated labor unrest and a breakdown of traditional sources of moral authority, especially the authority of the family and the Catholic Church. The diverse cultures and religions of the Midwest and Trans-Mississippi West challenged the church's authority as well. Leaders sensed that significant Catholic populations existed with inadequate spiritual institutions. To tap this growing group, the church created separate hospitals, orphanages, and schools and defined them along religious lines. Nuns staffed these facilities in which they could preserve the Catholic identity. They focused much of their attention on social welfare for their own; that is, for working-class immigrants. As a result, nuns had a large role to play in the shift of medical practice from homes to hospitals that occurred in the late nineteenth century.

As sisters expanded their health care in the wake of immigration, most saw themselves as missionaries in a country dominated by Protestantism. To carry out their work and serve more people, they had to build their communities and institutions. As a result, the Sisters of St. Joseph, Sisters of the Holy Cross, and Sisters of Charity of the Incarnate Word, along with scores of others, fashioned new religious lives for themselves and developed the means by which they could carry out entrepreneurial activities in the public domain of the hospital. To understand their hospital roles, an exploration of the historical development of Catholic health care is helpful.

**Early Christian Nursing**

A nursing tradition developed during the early years of Christianity when the benevolent outreach of the church included not only caring for the sick but also feeding the hungry, caring for widows and children,
clothing the poor, and offering hospitality to strangers. The religious ethos of charity continued with the rapid outgrowth of monastic orders in the fifth and sixth centuries and extended into the Middle Ages. Monasteries added hospital wards, where to “care” meant to give comfort and spiritual sustenance. This provided a rationale for nursing the sick to become a function of community life for both male and female religious orders. The fact that nuns were nursing in hospitals did not mean, however, that they became nuns specifically to nurse and do other good works. Engaging in ministry was irrelevant to their primary goal of personal sanctification through asceticism or prayer. Thus, whatever work they performed was done not as a ministry but rather as ascetic training for the soul’s perfection.

A real innovation began in the seventeenth century and continued into the late nineteenth and early twentieth centuries when male and female “apostolic” or “active” orders developed with ministerial works as essential missions. At that time, many women across Europe, both Catholic and Protestant, responded to their churches’ calls for evangelical conversions and revival. In particular, the Catholic Counter-Reformation in France witnessed a rapid expansion of new communities of women religious. An important development for nursing was the foundation of the Daughters of Charity by Vincent de Paul and Louise de Marillac in 1633. This “active” community of unmarried women and widows lived together and dedicated themselves to charitable works, including serving the sick poor. Many other women followed the Vincentian framework, which joined humility, obedience, and simplicity to good works, and they practiced nursing as an imitation of Christ’s charitable qualities.

**Catholic Sisters in the United States**

In the United States, nuns framed their hospital roles after Vincent de Paul’s model. They had extensive experience caring for people outside the home environment. In the mid-nineteenth century, some “natural-born” or “professed” nurses cared for nonfamily members to provide an income for themselves, but most women in the United States were unaccustomed to caring for strangers. They provided nursing care in the home as part of their domestic duties and mainly tended family members or friends. By contrast, when women joined a Catholic religious community, they intentionally accepted the inherent caretaker role for persons beyond their own circle of family and friends. During epidemics, when others fled cities, nuns remained to care for the sick and dying. While no formal training
programs existed, sisters learned by experience in their hospitals and by visiting the sick at home.\textsuperscript{11}

Sisters’ hospitals evolved from a general institution for the indigent, which provided multifaceted services for the sick poor, widows, the aged, and children. Catholic hospitals also grew out of other more clearly medical contexts: epidemics, wars, railroad and mining injuries, and the need for hospitals for sick sailors.

The degree to which sisters were able to establish entrepreneurial programs of their choosing depended on their using a variety of strategies. By the 1850s, the American Catholic Church had moved away from lay trusteeism and congregationalism and had accepted the hierarchical authority centralized in the papacy. This model emphasized order, control, subordination, and disciplined uniformity.\textsuperscript{12} In the nineteenth century, when nuns’ communities were small, they sought legitimacy and support from local ecclesiastical authorities. As congregations grew, however, and circumstances demanded more extensive services, sisters resisted the limitations placed on them by the church hierarchy. Some orders remained under diocesan control, and the diocese rather than the religious congregation owned the hospitals. Others centralized their communities across diocesan lines, with a central motherhouse and female superior who would have authority over all the other houses. Eventually, provinces would be formed in areas where there were large numbers of sisters and institutions, and they remained tied to the motherhouse through a system of general government.

Sisters were careful to record their distinct governmental roles in their constitutions, to which they could appeal when necessary. Constitutions articulated sisters’ beliefs about their ministerial priorities, rights, responsibilities, government structures, and relationships with ecclesiastical superiors. As nuns wrote and rewrote constitutions, they were not simply adopting standard forms of behavior. These documents, in fact, were extremely important in creating an area of specialty for the community to do certain work and maintain its independence. So valuable was nuns’ independence that they spent a great deal of time refining constitutions to support their area of service.\textsuperscript{13} While these revisions may appear muted because they took place within the framework of service, minor changes reflected major assertions of independence.

Women’s congregations turned the increased church centralization to their advantage. By 1915, each of the three congregations in this book had established itself as a papal community. As such, they were directly responsible to the pope rather than the local bishop, and this checked bishops’ interference with their work.\textsuperscript{14} It would prove to be a key factor in sisters’ hospitals, which they rather than the diocese owned.
In the United States, Catholic sisters linked charity and market activities for charitable reasons. This strategy had long been successful for them in Europe, where they had contracted with government and medical authorities to run hospitals in which they could combine evangelism with nursing skill. In 1823, nuns first began staffing hospitals in the continental United States at the Baltimore Infirmary, where they charged a small fee for admission. Here, university officials asked the Sisters of Charity from Emmitsburg, Maryland (later known as the Daughters of Charity), founded by Elizabeth Seton, to staff the infirmary. Between 1828 and 1860, this congregation established eighteen hospitals in ten states and the District of Columbia, more than half the Catholic hospitals founded before 1860. They cared for medical and surgical cases and patients with mental disorders, and they were particularly active during epidemics.\(^{15}\)

The epidemic-stricken cities of the mid-nineteenth century needed hospitals immediately. Another religious congregation that became permanently involved in nursing at this time was the Sisters of Charity of Nazareth. After the cholera epidemic of 1832, they began caring for the sick in Louisville, Kentucky, under the direction of Mother Catherine Spalding. In 1842, they started a hospital in Nashville, Tennessee. During the cholera and yellow fever epidemics between 1830 and 1840, the Sisters of Charity of Our Lady of Mercy worked in a hospital in Charleston, South Carolina. Although racial discrimination limited African Americans’ institutional development, two communities of African American women—the Oblate Sisters of Providence, founded in Baltimore in 1828, and the Sisters of the Holy Family, founded in New Orleans in 1842—also cared for the sick during epidemics. The Oblate Sisters nursed over two hundred patients in the Baltimore Almshouse during the 1832 cholera scourge. In New Orleans in the 1850s, the Sisters of the Holy Family cared for victims of cholera and yellow fever and also established a ministry to the aged.\(^{16}\)

As the unprecedented immigration of the 1840s and 1850s enlarged the medical market, social and religious roles for Catholic sisters expanded. The daily arrival of immigrants, the church’s fear of Protestant proselytizing, and the social problems brought on by urban growth all provided opportunities for nuns to establish hospitals in the United States. While Protestant growth occurred particularly in the southern regions of the country, Catholic enclaves of European immigrants predominated in eastern cities such as New York, Boston, and Philadelphia, and midwestern cities such as St. Paul, St. Louis, and Chicago.
The Catholic Church was in the minority in Texas and Utah, but these areas attracted many immigrant miners and railroad workers from Catholic countries who were potential American Catholics. In the mid-nineteenth century, anti-Catholic nativist sentiments occurred in response to the growing Catholic population and influenced Catholic institutions. Protestant hostility arose from anxieties over Catholics’ obedience to the pope and priest, which Protestants thought was incompatible with republican citizenship and religious freedom. Catholic leaders counterattacked nativism by attempting to demonstrate the church’s compatibility with American democracy. Because of the prevailing anti-Catholicism, Catholics formed strong attachments to their own institutions.

It is difficult to determine the exact number of hospitals that various women’s religious groups established because of the lack of record-keeping and the humility of the nuns who did not wish to call attention to themselves. Nevertheless, some data do exist. From 1840 to 1870, nuns from thirty-four different congregations either established or took charge of more than seventy acute hospitals in the United States. Many came from Europe, including the French Congregation of the Sisters of St. Joseph, who arrived in the United States in 1836. From 1849 to 1859, they staffed St. Joseph’s Hospital in Philadelphia, largely to care for Irish immigrants. They also opened a hospital in Wheeling, Virginia (now West Virginia) in 1853 and St. Joseph’s Hospital in St. Paul, Minnesota, in 1853. Another important community was the Sisters of Charity of St. Augustine, who came from France to begin St. Joseph’s Hospital in Cleveland in 1852 (later reestablished as St. Vincent’s Charity Hospital).

Irish women were particularly active. A prominent community that augmented nursing in the United States after 1840 was the Sisters of Mercy, founded by Catherine McAuley in Dublin in 1831. The sisters arrived in the United States in 1843 with a history of caring for the sick poor in homes and in hospitals. The need for hospitals in the Midwest evolved much as it had for eastern cities as disease and injury followed the many immigrant laborers. In the 1840s, they established a hospital in Pittsburgh. Then in 1846, after bouncing in stagecoaches across Pennsylvania, Ohio, and Michigan, they arrived in Chicago, where they incorporated Mercy Hospital in 1852. The Sisters of Mercy also went to Vicksburg, Mississippi, where they nursed victims of war and epidemics. Another group of Irish Sisters of Mercy under the direction of Mother Baptist Russell arrived in San Francisco in 1854 and founded St. Mary’s Hospital after a cholera epidemic had ravaged the city.

Wars provided ideal proving grounds for sisters because their nursing
during these conflicts helped improve negative perceptions of Catholics. Nuns’ nursing service during the Civil War brought just such an opportunity. As a result, the public’s perceptions of sisters and the Catholic Church itself improved dramatically. Thereafter, congregations such as the Sisters of Providence of Saint Mary-of-the-Woods, Indiana; the Sisters of the Holy Cross; and the Sisters of Charity of the Incarnate Word became involved in health care.

Catholic women’s congregations were particularly active in following the immigrant into new industrial, railroad, and mining centers in the Trans-Mississippi West. The Sisters of Charity of Nazareth became the nucleus of the Sisters of Charity of Leavenworth, Kansas, who established hospitals in Leavenworth; Helena, Montana; Denver, Colorado; and Butte and Anaconda, Montana; to care for miners, loggers, and railroad workers. The Sisters of Mercy opened pioneer institutions in Iowa and Nebraska, and the Presentation Sisters were active in South Dakota. Hospital care in New Mexico can be traced back to another branch of the Sisters of Charity, who established St. Vincent’s Hospital in Santa Fe in 1865. In the Pacific Northwest, the French-Canadian Sisters of Providence were particularly active in hospital development. Led by Mother Joseph Pariseau, they came from Montreal in 1856 to open a hospital in Vancouver, Washington. In 1873, they established St. Patrick’s Hospital in Missoula, Montana. By the end of the nineteenth century, they had established eleven hospitals.

Sisters from Germany opened health-care institutions in areas with especially large numbers of German immigrants. The Sisters of the Poor of St. Francis immigrated to the United States in 1850 and established hospitals in Ohio, Kentucky, New Jersey, New York, Kansas, and Illinois. Another Franciscan congregation, the Sisters of the Third Order of St. Francis, established their first hospital in Philadelphia in 1860. A branch of this order, which became an independent community and called themselves the Sisters of the Third Franciscan Order, Minor Conventuals, cared for victims of leprosy in the Hawaiian Islands, a ministry that eventually included the facility at Molokai.

**Catholic Hospitals, 1870–1920**

From 1870 to 1920, 189 different congregations established 275 Catholic acute-care hospitals. By 1870, Boston had received large numbers of Irish immigrants, and about 20 percent were women whose mortality from childbed fever was especially high. In 1872, five Irish immigrant
nuns from the Third Order of St. Francis established St. Elizabeth’s Hospital for Women in Boston. The facility soon expanded to become all-inclusive, requiring a change in the hospital charter so that “its benefits should not be limited to female.” Still, the hospital’s commitment to women remained strong as it continued to care for women too poor and desperate to give birth at home.28

Because of religious persecution in Germany under Bismarck, additional German women’s communities sought refuge in the United States and opened hospitals across the Midwest. In 1869, the Poor Handmaids of Jesus Christ established their first hospital in Fort Wayne, Indiana, followed by one in Chicago and another in Mishawaka, Indiana.29 The Sisters of the Third Order of St. Francis expanded their work in Illinois, which included the founding of St. John’s Hospital in Springfield in 1875. That same year, the Poor Sisters of St. Francis Seraph of the Perpetual Adoration opened St. Elizabeth’s Hospital in Lafayette, Indiana, one of twenty health-care institutions they established across the Midwest in the late nineteenth and early twentieth centuries. Many of these hospitals were founded to strengthen group cohesion for German immigrants, particularly in the areas of language and devotional life.

Other hospitals followed similar paths. Between 1866 and 1894, the first community of nursing brothers in the United States, the Alexian Brothers, opened hospitals in Chicago; St. Louis; Elizabeth, New Jersey; and Oshkosh, Wisconsin. The Daughters of Charity continued their hospital expansion, opening St. Vincent’s Hospital in Indianapolis in 1881 and many others across the United States. The Sisters of the Sorrowful Mother came from Rome in 1889 and opened ten hospitals in the Midwest and Southwest.30 Beginning in 1891, Mother Frances Cabrini and the Missionary Sisters of the Sacred Heart established hospitals in New York, Chicago, and Seattle to care for Italian Americans. Also in 1891 Katherine Drexel, an heiress from Philadelphia, founded the Sisters of the Blessed Sacrament for Indians and Colored People, and this community staffed nine different hospitals. In association with the well-known Mayo Clinic, the Sisters of St. Francis of Our Lady of Lourdes opened St. Mary’s Hospital in Rochester, Minnesota, in 1889.31

Sisters nursed in 1898 during the Spanish-American War, and eventually 282 nuns either volunteered their services or were asked to serve by government and military officials. Twelve Sisters of the Holy Cross and eleven Sisters of St. Joseph of Carondelet went to the Division Hospital at Camp Hamilton, Lexington, Kentucky; and then to different camps in Georgia, with the Sisters of St. Joseph going on to nurse in Cuba. At Camp Hamilton, Holy Cross Sister Lydia Clifford, a Civil War nurse
who had experience in other hospitals, was “Chief Nurse.” Under her, fifty Sisters of Charity from Emmitsburg, Maryland, the eleven Sisters of St. Joseph, (fig. 1.2), and over fifty lay nurses shared nursing responsibilities with the Sisters of the Holy Cross.32 Sisters also established specialty hospitals in the form of mental and tuberculosis institutions. By 1925, there were 581 Catholic acute and specialty hospitals in the United States, mainly under the auspices of nuns.33

This does not suggest that Catholic sisters were the only group of women motivated by religion to establish health-care institutions. Lutheran and Episcopalian deaconesses opened hospitals beginning in the mid-nineteenth century, and Mormon women established institutions in Utah in the early twentieth century.34 Every denomination viewed health care as part of its mission. While many women’s religious communities were involved in hospitals, the three Catholic congregations in this book were chosen to illustrate the theme of nuns’ entrepreneurship in the Midwest, Texas, and Utah. Each group was active in the hospital field, and each possessed a distinct ministerial focus that gave members a special direction for their lives.

FIGURE 1.2 Catholic sister-nurses in the Spanish-American War. The Sisters of Charity are in the back row, Sisters of St. Joseph in the middle, and Sisters of the Holy Cross in front. (Courtesy Sisters of the Holy Cross Archives, Saint Mary’s, Notre Dame, IN)
Foundations of the Three Communities

Sisters of St. Joseph of Carondelet

The Jesuit priest Jean Pierre Medaille founded the Congregation of the Sisters of St. Joseph in Le Puy, France, sometime between 1646 and 1651. The sisters aimed to serve the community, and, in spite of ecclesiastical law, did not observe canonical cloister. Their constitution stated that they were to carry out “all the spiritual and corporal works of mercy of which woman is capable.” The sisters typically were daughters of farmers and laborers, and they performed a variety of services to their neighbors, including education of girls, service in hospitals, direction of orphans’ homes, upkeep of dispensaries, and visitation of the sick poor. The flexibility they enjoyed by not being restricted to any specific work allowed them to respond to needs and situations as they arose.35

By 1789, the Catholic hierarchy held a privileged position in France, and it had the support of the aristocracy. However, the French Revolution shattered the church’s dominant position, and religious congregations of men and women experienced tremendous upheaval. Hundred of priests and even some sisters were executed. In the aftermath, older nuns and new recruits reorganized the Sisters of St. Joseph community in 1807 under the direction of Mother St. Jean Fontbonne. She, too, had been imprisoned during the revolution but was spared from execution when Robespierre fell from power.36

As the Catholic Church revived in the post-Napoleonic era, the sisters expanded their works and prepared for missionary endeavors. In 1836, a wealthy French benefactor was aware of the sisters’ flexible rule that supported their “readiness for anything,” and when Bishop Joseph Rosati sought nuns for his newly established diocese in St. Louis, she convinced him to ask the Sisters of St. Joseph. Mother St. Jean agreed and sent six nuns in March of that year. They eventually established their motherhouse in Carondelet, just south of St. Louis. Between 1847 and 1857, they moved into other cities, including St. Paul, Toronto, Wheeling, Buffalo, Hamilton, Brooklyn, and Albany. In the following years, they expanded into regional provinces or organized within different dioceses.37 As they established schools and orphanages, they obtained experience in business methods, which they could draw upon when they founded hospitals.

The sisters reacted spontaneously to needs as they arose. In the early years, they cared for cholera victims in St. Louis, Philadelphia, and St. Paul. They nursed in the Civil War and again in the Spanish-American War. After opening St. Joseph’s Hospital in 1853 in St. Paul, the sisters...
took over St. Mary’s Hospital in Minneapolis in 1887. Other health-care
institutions included those in Kansas City (1874); Georgetown, Colorado
(1880); Prescott and Tucson, Arizona (1878, 1880); the Minominee
Indian Reservation in Keshena, Wisconsin (1886); Hancock, Michigan
(1899); Fargo, North Dakota (1900); Grand Forks, North Dakota (1907);
and Amsterdam and Troy, New York (1903, 1908).38

For their entrepreneurial activities to be successful, congregations
needed ecclesiastical support. The sisters’ coming to St. Paul resulted from
networking between themselves and the area’s local bishops, who were
aware of the nuns’ work in St. Louis. No doubt, their French connections
made them attractive as well. Bishop Joseph Cretin of St. Paul was trying
to establish a school for the many immigrants from French Canada, as
well as local Native Americans and other European immigrants. After
Mother Celestine Pommerel agreed to Cretin’s request for sisters, partic-
ularly because his invitation gave them the opportunity they wanted to
teach Native Americans, the French-born Mother St. John Fournier
agreed to accompany, as their superior, three other Sisters of St. Joseph.39
In St. Paul, however, bishops soon monopolized their work to serve Euro-
pean Catholics.

One of the earliest postulants was Sister Seraphine Ireland. Born Ellen
Ireland to Irish immigrant parents, she entered the novitiate of the Sisters
of St. Joseph in St. Paul in 1858. In 1882, she became provincial superior
and led the group for the next thirty-nine years. Her patronage connec-
tions included her own family: throughout her tenure, her community had
the support of her brother, Archbishop John Ireland of St. Paul. By 1900,
the sisters listed 428 members in the St. Paul area. In addition to their
hospitals, they staffed twenty-three other institutions that included
schools, orphanages, and homes for dependent women. In 1905, they
opened the College of St. Catherine.40

Sisters of the Holy Cross

Unlike the Sisters of St. Joseph, who brought a health-care tradition with
them to the United States, the Congregation of the Sisters of the Holy
Cross was not founded initially for nursing but rather as domestic helpers
to priests and brothers at Notre Dame de Sainte Croix. Father Basil
Anthony Moreau established the women’s community in 1841 in Le
Mans, France. Moreau’s male order had an evangelical focus, and in 1841,
the first band of Holy Cross men, including Father Edward Sorin, arrived
in northern Indiana. The population of Native Americans in the area and
eventually German and Irish immigrants, many who were nominal or
potential Catholics, made northern Indiana prime missionary territory. In 1842, Sorin established what became the University of Notre Dame, and he requested sisters to help with domestic chores there. His letter to Father Moreau described his reasons for wanting sisters: “Once the sisters arrive—and their presence is ardently desired—they must be prepared not merely to look after the laundry and the infirmary, but also to conduct a school, perhaps even a boarding school.” The nuns arrived in 1843, and while they initially did housekeeping tasks for the priests and brothers, Father Sorin had opened up the possibility of a school. Soon, the sisters moved beyond domestic tasks to teaching and visiting the sick. In 1844, they established Saint Mary’s Academy, which eventually became Saint Mary’s College.

Father Sorin’s influence on the sisters was profound, providing the classic example of the importance of ecclesiastical leaders to a religious order’s interests and belief systems. He frequently used the language of assurance to convince the sisters of their importance. The Rules of 1871 were the first to contain the Preface which he wrote and which still exists...
in the 1982 constitution. The sisters were to accomplish their aims with a “spirit of faith” that would be a shield against all of life’s tribulations, and their expectation of eternal reward should sustain and strengthen them. Sorin’s influence also affected the leadership of the community. From a prosperous family in France, he expected the sisters’ leaders to have a similar cultural and educational background. Mother Angela Gillespie (fig. 1.3) met these qualifications.

Mother Angela was born in Pennsylvania to second-generation Irish parents, and her relatives included statesmen and senators. Not only did she have political connections but also education, teaching, and business experience. These qualities gave her opportunities to wield significant influence. In 1853, she joined the Congregation of the Sisters of the Holy Cross and became the first American Directress of Saint Mary’s Academy. She guided the sisters for more than thirty years.

“Keeping with the needs of the times,” from Father Moreau’s 1841 circular letter, became the core of the sisters’ mission. They added practices according to how well they served the overriding purposes of their congregation. For example, during the Civil War, Mother Angela led nearly eighty nuns as nurses on battlefields, in hospitals, and on hospital ships, primarily in the western theater of war. They also nursed on the Union Navy hospital ship Red Rover as it carried wounded men to army hospitals in the North. After the war, the sisters expanded their mission into hospital work. They established St. Mary’s Infirmary in Cairo, Illinois (1867); Holy Cross Hospital in Salt Lake City, Utah (1875); St. Joseph’s Hospital in South Bend, Indiana (1882); and other hospitals in Utah, Idaho, Dakota Territory, and Ohio, although teaching remained their primary work. They opened schools across the Midwest and Trans-Mississippi West and in Pennsylvania and Maryland. Membership grew from four in 1841 to 1,048 in 1915.

Sisters of Charity of the Incarnate Word

The Congregation of the Sisters of Charity of the Incarnate Word was founded specifically to meet health-care needs in Texas. It grew from a French cloistered religious order, the Order of the Incarnate Word and Blessed Sacrament, founded in Lyons in 1627 through the work of Jeanne Chezard de Matel. For Mother de Matel, devotion to the incarnated Christ became the symbol for her order’s way of life. Thus, the core of the mission was not solely Jesus’ deity but particularly his humanity, which brought him into the full human community. The Incarnate Word Sisters came to Texas in 1866 at the request of Bishop Claude Dubuis to
open a hospital for victims of cholera and yellow fever. Since they dedicated themselves to nursing, the sisters inserted the word “charity” in their name and became the Sisters of Charity of the Incarnate Word.

In 1867, the nuns opened the first Catholic hospital in Texas, St. Mary’s Infirmary, in Galveston. More French sisters came, and in 1869, Sisters Madeleine Chollet, Pierre Cinquin, and Agnes Buisson established Santa Rosa Infirmary in San Antonio, with Sister Madeleine becoming superior. A new constitution authorized expansion of the congregation’s purposes and works in 1885. Besides seeking personal sanctification of members, sisters were to care for the “sick, the insane, the poor, the aged,” and administer schools and asylums. After working with smallpox victims, the sisters added the following to their 1885 constitution:

In epidemics and contagious diseases the sisters must rise to the height of their sublime vocation, devoting themselves, at the peril of their lives, to the sick, who need their services, without regard to creed or color, and their most anxious care shall ever be for the poorest and most abandoned.

This statement supports the idea that the mission of the community was charity to the poor, but it also provides insight into other aspects of the nuns’ work. By caring for victims of epidemics, sisters had access to a population with a high mortality rate. Sister-nurses could bring not only physical comfort but also spiritual consolation. Furthermore, nursing was to be a sacrificial act in which nuns must be prepared to die to further their Christian message.

The Incarnate Word Sisters opened homes for the aged and mentally ill, rehabilitation facilities, and general hospitals in Boerne (1896), Amarillo (1901), Corpus Christi (1905), San Angelo (1910), and Paris (1911), Texas. They staffed already existing hospitals in Forth Worth (1885) and then in Marshall (1995). By 1890, they directed seven additional railroad hospitals in Tyler and Palestine, Texas; Las Vegas, New Mexico; Fort Madison, Iowa; and St. Louis, Sedalia, and Kansas City, Missouri. They began operation of Incarnate Word Hospital in St. Louis in 1902. In the process, they learned ways to procure land, buildings, materials, funding, and a growing clientele. In 1900, they established an academy for girls and young women in San Antonio that was the foundation for the College and Academy of the Incarnate Word. By 1919, the congregation had grown to 663 members. In addition to numerous schools and orphanages, they had twelve hospitals and two homes for the aged.

Two women, in particular, were influential in the community’s foundation. Although the sisters recognize Bishop Dubuis as their founder,
they also acknowledge Mothers St. Madeleine Chollet, the first superior, and St. Pierre Cinquin (fig. 1.4). Born to a wealthy family in France, Mother St. Pierre received her education from the Ursuline nuns. After entering the Incarnate Word convent in France and then immigrating to the United States, she became the second superior of the San Antonio community. Her entrepreneurial impulse to build her congregation was seen in its significant growth in personnel, institutions, and clients.52

Through their establishment of many institutions, nuns in all three congregations learned not only teaching and nursing skills but administrative ones as well, which they could apply as they managed large hospitals. By 1910, many of their health-care facilities held from one hundred to two hundred beds and typically admitted 1,000 to 2,000 patients per year. These hospitals were smaller than the large public facilities in the East, but according to a 1910 national study, sisters' hospitals were some of the larger ones in the country.53

Figure 1.4 Mother St. Pierre Cinquin, CCVI. (Courtesy Archives, Motherhouse of the Incarnate Word, San Antonio, TX)
ISSUES REGARDING WORK

Many factors influenced whether or not sisters’ nursing and entrepreneurial activities in hospitals would be successful. First and foremost, there had to be a market for their services, a topic to be considered in the following chapters. The Sisters of the Holy Cross and Sisters of St. Joseph had to close miners’ hospitals in Utah, South Dakota, Colorado, and Arizona when the mines failed and the nuns could no longer financially maintain the hospitals. For the same reason, they closed railroad hospitals when the railroad companies left an area.

Second, congregations needed significant numbers of recruits to staff the institutions. Preexisting networks of women from similar ethnic and socioeconomic backgrounds and those who were available for participation provided the focus for major recruiting drives for potential nuns. Ireland particularly was a fertile field for gleaning recruits. Irish girls found communities in the United States especially attractive because many did not demand large dowries. Instead, they required education, which the Irish had. The Irish church also was the only European one offering English-speaking women. As early as 1845, the imbalance in favor of the Irish began for the Sisters of the Holy Cross. That year, eight women, all but one of Irish birth, received the habit. During the Civil War, three-fourths of the nearly eighty Holy Cross sisters who nursed in the conflict were born in Ireland.

An intense spirit of competition occurred among women’s communities in obtaining Irish recruits. In the 1870s, Mother Angela Gillespie of the Sisters of the Holy Cross made several recruiting trips to Europe. She began in Dublin and spoke at places where large numbers of Catholic girls congregated, including sodalities, or parish devotional societies. From there she went to convents and schools across Ireland, including Kildare, Kilkenny, Limerick, Waterford, and Cork. One Kilkenny priest remembered her visit: “She succeeded in getting twenty-five young ladies for her order in the United States, and they all persevered. She now desires twenty-five more and has come over to search for them.” On their part, Irish recruits desired opportunities to teach, nurse, and administer hospitals alongside the many Irish women already in American congregations. In 1873, of the ninety-three women who entered the Holy Cross congregation, sixty-one were Irish-born. In 1898, fifty-seven aspirants left Ireland to join the Sisters of St. Joseph of Carondelet in St. Louis.

Other historians have assessed the kinds of Irish families whose daughters were so readily drawn to convents in the late nineteenth and early twentieth centuries. Many of these families were headed by factory workers, shopkeepers, or cattle and dairy farmers. While some recruits
came from impoverished families in the south and west of Ireland, it appears that others came from both rural and urban middle-class or lower-middle-class families.\textsuperscript{61}

Since the Incarnate Word Sisters settled in Protestant Texas, they had few Catholic candidates initially from which to recruit. Out of necessity, this congregation was particularly aggressive in recruiting women from Ireland. They obtained many from Irish sodalities such as Dublin’s Children of Mary at Our Lady’s Hospice, Harold’s Cross. In 1900, Mother Mary John O’Shaughnessy, a former Child of Mary herself, brought back forty women to San Antonio from various locales in Ireland. Four years later, another Incarnate Word sister left Dublin with thirty-eight more.\textsuperscript{62}

After the turn of the century, the sisters continued recruiting in Europe, particularly Ireland and Germany (table 1.1). From 1872 to 1920, Irish women made up nearly half the congregation. The others came from Germany, the United States, Mexico, France, and Canada.\textsuperscript{63}

Elements of Irish culture influenced the sisters’ hospital foundations. Irish women were accustomed to a tremendous amount of physical labor. In Ireland, women often did the most strenuous jobs at home or on the family farm,\textsuperscript{64} and they adapted well to the hardships of nursing in American hospitals. Furthermore, women from cattle-farming families in Ireland were used to hearing talk of buying, selling, and deal making. When, as superiors of hospitals, these women negotiated prices for the “best deal,” they faced conditions they likely had experienced at home around the family table.\textsuperscript{65} Hasia Diner has described Irish immigrant women in America as survivors. After the famine, they “saw themselves not as passive pawns in life but as active, enterprising creatures who could take their destiny in their own hands.” Their optimism and their strong sense of self, their emphasis on economic priorities, combined with a rigorous Irish Catholicism that emphasized discipline, obedience, and devotion, facilitated their accomplishments in the hospital marketplace.\textsuperscript{66}

<table>
<thead>
<tr>
<th>Year</th>
<th>Ireland</th>
<th>Germany</th>
<th>United States</th>
<th>France</th>
<th>Mexico</th>
<th>Canada</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1872–1900</td>
<td>45%</td>
<td>21%</td>
<td>16%</td>
<td>8%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>1901–1920</td>
<td>47%</td>
<td>21%</td>
<td>14%</td>
<td>2%</td>
<td>14%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Archives, Motherhouse of the Incarnate Word, San Antonio, TX.
This is not to say that French or German nuns did not have economic achievements, because they did. Nor is this to say that hard work and faith alone enabled sisters’ successes. Nuns from Ireland, Germany, and other northern European countries accrued economic and social advantages from their acceptance as “whites.” They worked in a society in which skin color determined social standing. Indeed, whiteness proved a valuable asset for doing well in the United States, an advantage the African American religious communities that had to function in a segregated society did not have. Other Old World connections were important, as well. The Incarnate Word Sisters relied on the Lyons nuns to help in recruiting French women to the Texas community, especially in the early years. And there was a great reliance on social networks of family members, friends, and neighbors. Many women had birth sisters, aunts, or other relatives in a convent. Holy Cross Sister de Sales O’Neill, from County Cork, Ireland, had seven members of her immediate family in religious communities.

European elements merged with a third factor influencing sisters’ success: their willingness to adapt to changing circumstances. As nuns came to understand the American environment and the needs of their hospitals, they saw that adaptations had to be made if they were to survive financially and be successful in meeting their religious and entrepreneurial goals. Timing was important: they had to change as market forces changed. European women entering communities in the United States were especially influenced by the American sense of “fair play” and independence, which caused conflict when French motherhouses attempted to interfere with American groups. Furthermore, because of time and distance, communication problems developed between nuns in the United States and their French administrations. By 1925, the Sisters of St. Joseph, Sisters of the Holy Cross, and Sisters of Charity of the Incarnate Word had become independent of their French motherhouses.

As they positioned themselves for growth, the congregations rapidly took on an American identity. Americanization can be seen as a competitive response as institutions in the United States continued to grow. Indicating the imperatives of language, sisters began taking English lessons shortly after their arrival in the United States, and leaders had constitutions printed in English. The English language also was a recruitment strategy. Religious communities had to have American women to survive in the United States, and encouraging the use of English made congregations more attractive to American recruits. Congregations deliberately sought American-born members soon after their arrival. Another significant element in the Americanization process was sisters’ work as nurses during the Civil War and Spanish-American War.
Through their wartime experiences, sisters developed a deeper sense of identity as Americans, and they expanded their horizons. Because respectability was always a concern, nuns were anxious to show their patriotism, and their participation as wartime nurses not only affirmed their own loyalties but also symbolized those of the Catholic Church itself.

A fourth factor that influenced sisters’ ventures was their support systems. Hospital successes typically reflected available funds, and nuns had to appeal to legitimate networks of patronage to gain the financial support they needed. The early enterprises of the Sisters of St. Joseph materialized primarily through their patronage relationship with the French countess who helped support them financially. Other superiors worked directly with prominent local citizens, businessmen and women, railroad companies, and mine owners to obtain support for their activities. Teaching young women from middle- and upper-middle-class families was a standard means through which nuns could cultivate relationships with wealthy parents. Despite the “token” support of the Catholic Church for black women’s religious communities, Katherine Drexel was able to use the millions of dollars left to her by her father, a partner of the banker J. P. Morgan, to help African Americans. Priests and bishops sometimes served as intermediaries for nuns. Archbishop John Ireland of St. Paul was known to have favored his sister’s community, the Sisters of St. Joseph, over other women’s congregations in his diocese, and he often maneuvered to give them advantages over certain territorial operations.

Autonomy over their work was a fifth factor that influenced sisters’ hospitals. Ordinarily, sister-superiors made nuns’ work assignments and the final decisions regarding which new activities the congregations would undertake. Communities refused requests for their services when they did not have the available personnel, and superiors exercised this authority frequently. Often there were far more requests for services than nuns could accept. For several years, the Incarnate Word superior turned down an opportunity to open a hospital in West Texas because there were not enough sisters to nurse in another institution. They also left a facility after conflicts over a physician’s financial management and his demand for lay nurses.

Tensions persisted over the tasks that nuns should perform and who should be responsible for organizing them. In choosing opportunities for work, sisters cited the identity of the order and its mission. The Sisters of the Holy Cross, while professing obedience to superiors, were not eager to accept new housekeeping assignments. By 1870, their constitution clearly spelled out their work as teaching, nursing, and administering...
orphanages rather than housekeeping tasks that Father Moreau initially had stipulated. Thus, one way nuns could maintain independence was to cite their specialty as a defense. In this way, obedience could work in conjunction with autonomy.

Women's religious communities also called on their histories in defining their missions, and this influenced their decisions to take on new works. The Civil War experiences of the Sisters of the Holy Cross gave nursing a prominence in the congregation's identity that translated into more medically centered roles for them. Their prompt response for nurses during the Civil War influenced their decision to nurse in another national conflict, the Spanish-American War. Although the flexibility of the Sisters of St. Joseph enabled them to take advantage of a variety of opportunities, it also had its disadvantages. Sisters often became a cheap labor source for church committees and bishops, especially after the 1884 Third Plenary Council in Baltimore directed the establishment of parochial schools. Some bishops considered nuns as their own agents to summon when needed.75

Thus, sisters were subject to church authorities and were not expected to act alone. All major decisions by religious communities had to have the approval of the bishop or his representative. While sisters often wrote that a priest had invited them into an area, sometimes this merely meant permission granted for endeavors that superiors had already started. Often they “shopped around” for the best opportunities for their congregations to carry out their hospital work. In 1889, Mother St. Pierre Cinquin made all the arrangements to purchase Fort Worth's railroad hospital and then wrote the bishop “for his blessing.” She had already obtained his permission to purchase land for building purposes, so she was reasonably sure that he would approve her actions. In the early twentieth century, another Incarnate Word superior was anxious to open a hospital in St. Louis, Missouri, where the sisters had recently established a novitiate. She corresponded with several medical leaders before accepting an offer.76 The bishop's permission was merely a formality.

Sisters' initial agreements with hospital authorities were crucial to their entrepreneurship, and they tried to prevent as many problems as possible. These agreements reflect an acute sense of business. Before agreeing to a new venture, nuns inquired about access to the sacraments, adequate housing, and spiritual directors. Invariably, they insisted on full control of hospital operations. That the sisters could make such demands is not surprising. Nuns' successful organization and management of other institutions enhanced their bargaining power. Sometimes physicians asked for specific women's communities because they knew the sisters could
financially support a hospital. Because of nuns' previous successes in hospital work, doctors trusted them with new financial ventures and often agreed to sisters' demands for control.

By the early twentieth century, Catholic sisters were active participants in the hospital marketplace in the United States. It was nuns, in particular, who went to new towns and frontier areas and became major players early in the hospital movement. They brought a tradition of nursing and hospital work that had been influenced by European sisters who had cared for the sick for centuries. As nuns took on American identities, they readied themselves to assert claims over nursing and hospital administration. They were not always able to realize their goals, however, without some form of compromise. This will be described in the next chapter.