As Bishop Scanlan described the Sisters of the Holy Cross after they opened Holy Cross Hospital in Salt Lake City, he reflected the clergy’s typical perceptions of sister-nurses. Such idealized sentimentality was characteristic of the clerical need for the “cult of true womanhood.” However, Catholic sisters who stood at the threshold of establishing and operating hospitals in the growing competitive market of the late nineteenth century challenged prescribed gender roles. Much more was required of them than mere acquiescence to self-sacrificial feminine service.

One of the defining characteristics of the Catholic hospital in the late nineteenth and early twentieth centuries was the way religious, economic, and social boundaries altered the authority within Catholic hospitals run by women religious. Nuns maintained a unique hierarchy over their hos-
pitals’ administrative and nursing affairs, but at the same time they had to use certain diplomatic strategies when working with medical and episcopal authorities. They also had to deal with the romanticized images assigned to them that emphasized their feminine spirituality while obscuring their technical and professional skills.

This chapter will focus mainly on sister-administrators, or superiors. The average sister did not have the individual authority that the mother superior had because each gave up individual power to the congregation’s good as a whole. In this chapter, power is treated in its material forms but also as a means of fashioning identities and behaviors. Nuns’ actions reflect a complex relationship between power and manners. While superiors often negotiated through tensions by confrontation and resistance, at other times they openly embraced assigned roles of meekness and deferential service. This removed the visible trappings of power and influence and reduced their threat to the bastions of male power. Ironically, it also enabled sisters to move with skill and purpose in fulfilling their service missions.

Relations with Physicians

Although sister-administrators appointed the hospital’s physicians and exercised inherent power within that role, nevertheless they had to remain cognizant of their identities as females and religious servants. They could not afford to openly challenge the prerequisite authority of the doctors. Indeed, nuns were very aware of their need for public association with physicians, whose social prestige was already accepted and on whom sisters relied for patients. In turn, the doctors, many of whom were Protestant, remained keenly aware of their indebtedness to the sisters for their employment within the Catholic hospitals. Thus, when conflicts arose, both sides were more likely to compromise than to engage in lengthy or contentious struggles.3

From the beginning, nuns deferred to physicians in medical matters. The first advertisement by the Sisters of Charity of the Incarnate Word for Santa Rosa Hospital in San Antonio promised physicians that they would “have the entire control over [patients] in the Hospital; and his prescriptions with regard to food, nursing, and medicines, will be strictly followed.”4 The 1867 constitution prescribed that, in working with the doctor, sister-nurses “will take care not to control his prescriptions or find fault with his manner of acting.”5 In their annual reports, nuns always credited physicians’ roles in the hospital’s success. A report from Santa
Rosa Infirmary was typical: “We could not have a hospital without our doctors. ALL HAIL TO OUR DEVOTED DOCTORS!”

Sisters also generally respected physicians’ professional freedom. One doctor recalled that, at Santa Rosa Infirmary, whether they were engaging in new surgical techniques or trying out suggestions by other surgeons, “our efforts never met discouragement or insurmountable opposition from the officials at Santa Rosa.” Had the physicians encountered outright refusal or even words of caution at every turn, they believed their effectiveness as surgeons would have deteriorated. He described the ideal relationship between a physician and hospital as “one which not only allows freedom to innovate, but freedom not to do so, the option of rejecting change if its institution represents no improvement. To our lasting benefit and that of the community which we served, Santa Rosa offered this freedom.”

Yet, because Catholic hospitals were both medical and religious institutions, a tension developed between medical men and women religious who were the hospital administrators. Each group expected to have power, and conflict between the two groups inevitably flared from time to time. Gender and religion often were determining factors in these internal struggles. Although their nursing fit in well with the developing role of woman as domestic caretaker, in their hospitals sisters also took on administrative jobs that men traditionally held. In these positions nuns had unusual authority, a quality typically considered “masculine.” On October 27, 1903, at Sister Lidwina Butler’s expressed wish, members of the Holy Cross Hospital medical staff held their first formal meeting. While doctors wanted more control in making decisions that were in their own best interests, they were not always able to get it. Their records repeatedly document them merely “seconding” and “advising” the superior, in this case, Sister Lidwina. In one case, the physicians noted that “as things are now we could only express a wish, which doesn’t amount to much in practical results.” Nevertheless, the physicians devised a constitution that spelled out ideas for their own organization. They had to submit it to Sister Lidwina “in order to determine what and how much she would approve, that we might act in accordance with her desire.” The physicians reflected their circumscribed position, however, when they stated, “We might as well burn it.”

This relationship between sister-administrators and physicians was unusual. By 1910, American medicine had made large strides toward increasing its social power. In large teaching hospitals such as Johns Hopkins, physicians managed the hospital budgets and subsumed nursing school finances under their own control. In other hospitals, male boards
of trustees handled detailed operations and judged which patients were worthy of admission. As charity hospitals transformed into medical institutions and financial problems increased, trustees sought men with backgrounds in business and in medicine for administrative roles.10

By contrast, nuns exerted a greater degree of authority as they developed and administered comprehensive medical institutions. They did not primarily rely on charitable contributions for funding, and donors and subscribers did not have a say in management. Furthermore, nuns could balance the increasing power of medicine through an alternative source of spiritual power. As “brides” of Christ and representatives of the Catholic Church, nuns had their own special status, and no layman could rival it.11 Catholic tradition was the basis upon which sisters claimed legitimacy, and they had the support of the Catholic Church behind their endeavors.12 One cross-national study of secular and religious medical settings recognized the special status that nuns had in Catholic hospitals. Sisters’ supernatural frame of reference, based on their religious vocations and church affiliations, gave them a distinct charisma. Only the senior doctors’ medical charisma could match the nuns’ religious charisma. Thus, the only laymen whose authority the nuns recognized were the medical staff.13

Sisters modeled their hospital organization on the hierarchical structure of the Catholic Church. A superior led the hospital sisters, and she had control over the management and direction of the facility. While nuns yielded medical authority to physicians, their constitutions stated that sister-nurses were to obey the authority of the sister-administrator in everything “temporal” and were not to submit to anyone, doctor or others, who disregarded their rules.14 Sisters served as hospital trustees, nursing supervisors, and heads of different floors and hospital departments. (See fig. 7.1.)

The superintendent of the nurse training school usually was a member of the religious community, as well. Sister-nurses also rarely worked under secular nurses. Nuns expected secular employees to obey the sisters and sometimes discharged them if they did not follow the nuns’ directions. In the hospital, all reported directly to the superior.

Relations between doctors and nuns differed in another way. Physicians were not deeply involved in the establishment of Catholic hospitals, and nuns’ status as owners could not be forgotten. The sisters’ hospital corporations held overall authority and responsibility for policy formation and operation decisions. Through their board presence, the nuns formulated philosophies and missions and protected the hospitals’ assets. The superior of each individual hospital exercised close control over equipment purchases, nursing assignments, applications for admission to the attending staff, and admission and billing procedures.
With a different perspective, Bayard Holmes, a Chicago physician writing in a medical journal in 1906, illustrated the unusual relationship that members of a religious order had with doctors. Specifically, Catholic hospitals could give physicians opportunities to obtain patients for their practice. Holmes acknowledged that “the interest of the religious sect or solidarity by which the hospital is organized makes each member of that association or body far and near a crier and drummer for their hospital,” and only incidentally for staff members. Yet many patients of the same religion were drawn there. Hence, “[t]o have a fervid religious sect, with a substantial, numerous and loyal hierarchy behind his hospital to sanctify it and fill it with devotees” was “worth more to a physician and surgeon than six columns a week” of blatant advertising in newspapers.15

Sister-administrators also had unusual relations with medical interns, who typically were subordinate to both the superior and the medical staff. The superior and Intern Committee made interns’ schedules and assignments in the various departments. But because many of the senior medical staff visited hospitals only a few hours each week, specific rules for

FIGURE 7.1 Nursing staff of Holy Cross Hospital, Salt Lake City, UT, approximately 1883. (Courtesy Utah Historical Society, photo # 19836)
Interns gave considerable authority to the superior as superintendent. Once interns arrived, they had to follow regulations similar to those for student nurses. In this way, sister-administrators and physicians hoped to impose order and control over interns’ behavior. Rules at St. Joseph’s Hospital, St. Paul, advised interns to maintain tidiness and order in their quarters and refrain from loud talking. They were expected to observe the “strictest decorum and the utmost courtesy to the nurses on duty.” Interns could smoke only in their quarters, could not play musical instruments or radios after 10:00 PM, and had to eat at specific times. Rules strictly forbade the use of alcohol, and interns found with it in their possession or who appeared at the hospital under its influence were subject to dismissal upon the superintendent’s complaint to the medical board. Interns could not professionally treat hospital employees unless requested to do so by the hospital authorities, including the superior or her representative. At St. Mary’s, Minneapolis, interns could not remain outside the hospital after 11:00 PM without the superior’s consent, and they had to accept her surveillance of their rooms.

The superior and physicians at St. Mary’s held that interns needed careful supervision in their relationships with patients as well. Reflecting the view of patients as recipients of Christian charity, rules directed interns to remember “that those placed professionally under their care are sick and helpless and thus especially objects of compassion. They are, in voice and manner to treat them as they would wish to be treated themselves, were the positions reversed.” Interns were to report any insubordination or violation of rules promptly to the superior and communicate with her about all matters affecting the welfare of the hospital and its patients. Understandably, interns had ambivalent relationships with superiors. While they held them in awe, they also feared them. One would hide in an elevator when a superior came on the floor. The daily routines, discipline, decorum, and maintenance of order reflected the sisters’ own convent training and indicated how important order and personal behavior were to the hospital environment. They also showed the respect that sisters expected, both for patients and for themselves.

**Hospital Control**

Nuns reserved the right to make executive decisions. At administrative meetings, sister-administrators and board members discussed business transactions, weekly expenses and receipts, and the hiring and firing of personnel. With doctors’ potential for power growing due to their
increased numbers, however, conflicts sometimes occurred between them and the nuns over hospital policies and staff. As owners and administrators, nuns held a measure of control over staff appointments. In the early twentieth century at Holy Cross Hospital, the superior first received the applications, after which physicians reviewed the applicants’ qualifications. Doctors then made recommendations to the superior, who had the final authority to accept or reject their decision. Both groups usually agreed, but the superior did not always approve the doctors’ choices. She controlled not only the hiring but also the firing of physicians. In 1909, the members of the Holy Cross Hospital medical staff were displeased over a pictorial history of the hospital that a physician had issued. Apparently he failed to mention the doctors. They requested that Sister Lidwina ask him to resign, which she refused to do.

Conflict also occurred over hospital privileges and open staffing policies. The Catholic hospitals did not restrict physician privileges to an elite group. Rather, by the turn of the century, most allowed “open-staffing” patterns that involved unrestricted use of the facility by any qualified doctor. On their part, nuns were pragmatic about allowing qualified physicians to practice. Sisters’ religious missions impelled them to grow in terms of numbers of patients served. Furthermore, they always felt the need to increase income. One way of meeting both imperatives was to increase the number of physicians whose patients could help fill hospital beds.

An editor of a national magazine noted that the move toward open staffing indicated in “which direction the current is moving . . . Experience has proved conclusively that ‘the open door’ to the hospital is a benefit, not only to the rank and file of doctors, but to the hospital. It pays in dollars and cents.” In 1909, a hospital administration guide stated, “If the staff had large and profitable practices, then a sufficient amount of money can easily be realized to defray the entire running expenses of the institution, supplying the care not only for the private patients, but also for the charity inmates.” Likely, this compelling argument tapped sisters’ entrepreneurial interests and influenced their decisions to open up the staff.

At the same time, hospitals were becoming essential to a doctor’s successful practice. Not only did hospitals provide access to patients but also to the x-ray, laboratory, and surgical equipment necessary for diagnosis and treatment. For various reasons, many doctors preferred closed staffing policies that restricted the institution to certain physicians. Those in closed facilities could treat greater numbers of patients than their colleagues and competitors in other hospitals. Often this meant excluding African American, foreign-born, Catholic, and Jewish doc-
In 1903 and again in 1904, doctors at Holy Cross Hospital criticized the open-staffing method, arguing that it led to disorganization, inefficiency, deficient record-keeping, and poor patient care. Staff regulations did not bind doctors who were not members of the staff, and members feared they would have no effective means of holding the other doctors to the same standards. Likewise, a 1913 editorial in *Hospital World* argued, “[T]he open hospital sees many tragedies, trains interns and nurses badly, secures poor records and is lamentably deficient in its contributions to medical science.” Whether nuns allowed open staffing specifically to help doctors from different ethnic, racial, or religious backgrounds is unclear. Significantly, they did not restrict their medical staffs to Catholic physicians. Because Catholic hospitals did not function primarily to distinguish among doctors, perhaps open-staffing decisions were easier for nuns to make.

Concern over open-staffing policies rose in several hospitals, but sisters generally held their ground on the issue when pushed. In 1900, the doctors at St. Joseph's Infirmary, Fort Worth, proposed to limit the number of physicians joining the staff, but Mother St. Madeleine Chollet took a firm stand. She wrote Dr. W. A. Adams, one of a group of doctors who had issued circulars describing themselves as “Surgeons in Charge.” She objected to this seeming exclusivity. She began in a tone of respect and humility: “We sincerely hope that you and your esteemed partner, may honor St. Joseph's with your patronage and that, on your part, dear Doctor, our relations may be as amicable as they were in the past.” She then proceeded to reaffirm their policy of opening St. Joseph's to all doctors, as they did at Santa Rosa Infirmary in San Antonio. In a letter to two other physicians involved in the incident, Doctors Thompson and Saunders, she used a similar style:

> With regard to the proposed changes, we must keep to our determination to let the public understand that St. Joseph's is open to all physicians. I thank you sincerely for suggesting not to get into difficulty again, by choosing a staff of a certain number; therefore we will omit all names and reserve the right to issue all circulars.

She then proceeded to offer specific hours just for them. She closed by graciously stating, “We regret that this has come up now, when everything was quiet, but you understand our position, dear Doctors, and sooner or later, this would have become a necessity.” Doctors Adams and Thompson had been with the hospital since its opening, and Dr. Saunders was a celebrated surgeon; thus, it was important that she maintain their favor.
A principal theme in many hospital studies is the competition between medical staffs and well-established male executives over policy decisions, particularly those involving admissions. As noted previously, in the nineteenth-century voluntary hospital, most institutionalized patients did not pay for hospitalization. As the primary benefactors, a lay board of trustees controlled admissions by evaluating patients according to their worthiness of charity. Typically this meant being stable members of the community who were temporarily victims of circumstance. Trustees evaluated all applicants for admission, and physicians had to plead cases to the board for prospective admission candidates. Subscribers and contributors could also nominate patients for admission. Thus, hospitalization depended on the individual goodwill of the trustees as sponsors. By the 1870s, however, responsibility for admissions was shifting to medical men and their categories of clinical diagnoses.30

By contrast, Catholic hospitals’ different funding patterns had distinct implications for control over admissions. Furthermore, much of the social function of Protestant hospital support did not apply in Catholic circumstances. Because of nuns’ tight control over finances, especially in the early years, the sisters often had final say in admission decisions. Mother St. Pierre Cinquin, as superior at Santa Rosa Infirmary, reserved the right to approve the admission of full charity patients. In these situations, she worked primarily with physicians who had to petition her to get their patients admitted.31 The nuns also wanted to insure that people who otherwise might go untreated would have hospital access. The Incarnate Word Sisters especially guarded this responsibility since their constitutions specified that they alone would have charge of the sick poor on the grounds that the patients would be “better cared for.”32

Control over admissions, however, was a negotiated process. Sometimes doctors refused to admit patients because their illnesses were either not serious enough or were of a chronic or terminal nature, and sisters complied. At other times, nuns found ways to circumvent physicians’ wishes. In 1889 at St. Joseph’s, Fort Worth, a doctor refused to see an orphaned, sick Egyptian boy, arguing that he “had not the conditions requisite” for admission. The nuns disagreed, however, and devised their own way of caring for him by hiring him to do light labor under their watchful eye until he could get well.33 Occasionally, sister-administrators banned certain doctors’ patients from the hospital. In 1909 at Holy Cross Hospital, Sister Lidwina Butler had a running disagreement with the county physician and eventually forced him to remove all his patients.34 Still, she worked to try to satisfy physicians’ wishes. The previous year, she had spoken at a staff meeting, stating, “Our doors are always open to char-
ity cases. Should such occur my action would be governed by the recommendations of your members.” Over time, medical men increasingly made decisions in Catholic hospitals but within the boundaries defined by the owners.

One way that doctors challenged hospital management was to criticize institutional costs and implicate hospitals in socialized medicine. In May 1903, at the Utah State Medical Association meeting, Dr. A. C. Maclean vehemently denounced the high prices that Salt Lake City institutions charged private patients. He also attacked doctors’ contract practice at the hospitals. Physicians at this time were still beleaguered by too many practitioners in their own field and by hospitals that took their patients from them and deprived them of admitting privileges. Doctors particularly feared a form of socialized medicine, by which large, powerful organizations, either government or private, dictated doctors’ income and practice conditions. Thus, physicians wanted to prevent any corporation from mediating between them and their private patients, and they worried about contract practice in which companies hired doctors to care for workers. From the physicians’ views, this practice interfered with their right to give care and charge patients according to ability to pay. Medical societies, for example, characterized the practice of payroll deductions for mining company doctors as exploitation, since company doctors would bid against each other and lower physicians’ fees. Hence, Maclean argued that the miners’ prepaid health insurance system was “an imposition upon the medical profession.”

Always watchful over the interests of Holy Cross Hospital, Sister Lidwina immediately wrote the local newspaper:

You don’t hear these doctors making any protest about their charges being too high. . . . They charge $200 or $300 for an operation that requires an hour or an hour and a half of their time. The sisters and nurses watch over these same patients day and night for two or three weeks. As the entire compensation for this care, for food, room and other attentions, the hospital charges only $10 to $25 per week, according to the kind of room the patient wants. . . . If these doctors who are objecting to the prices their patients pay only had the hospital bills to pay for a while, I do not think they would do so much objecting.

She concluded that the charges in Salt Lake City were much lower than in eastern hospitals, even though the cost of living in the West was higher. “Taking everything in consideration,” she wrote, “I do not think the charges are any too much.” Maclean’s censure did not result in any
obvious financial loss to the hospital, since donations for 1904 increased over previous years.39

Operating room policies also were sources of negotiation as doctors tried to exert authority over surgery. In Salt Lake City, Holy Cross Hospital doctors criticized the indiscriminate use of the operating room in 1904.40 Other kinds of dissensions arose at Santa Rosa Infirmary when the Incarnate Word Sisters reserved a surgical suite and special instruments for surgeons of the Herff family. The nuns justified their policy based on the doctors’ close association with the sisters since Santa Rosa’s opening and because of the physicians’ distinction in surgery. These special privileges led to complaints from other doctors.41 For the most part, however, sisters knew that their hospitals would fail without physicians’ support and often heeded doctors’ wishes. In 1898, a physician refused to allow a doctor from another city to see a patient at Santa Rosa, and the sisters did not protest.42 (See fig. 7.2.)

Nuns expected to have control over both sister-nurses and the secular nursing staff with a minimum of interference from physicians. Doctors could not directly discipline sister-nurses because their first loyalty was to the superior. Conflict over nursing, however, could and did occur. Fort
Worth was predominantly a Protestant city, and physicians worried that St. Joseph’s Catholic identification might deter patients from coming. They made the contentious request that a policy guarantee that Protestant nurses would always be on staff. Mother St. Madeleine firmly resisted such a restriction, stating: “We could not bind ourselves to keep always in our service Protestant nurses. We have not the least objection to employ them because we never make religion a condition on which we engage nurses or others. . . . If they give satisfaction as to gentleness, capacity and good character, that is all we ask of them, be they Protestant or Catholic.”

Politics of Modernization

By the early twentieth century, prerogatives of medical science were figuring prominently in physicians’ arguments as they agitated for more hospital control. In 1902, Dr. Harry Niles, gynecologist, surgeon, and staff member of Holy Cross Hospital, published an article in a professional journal in which he asked, “[D]o not our services justly entitle us to a voice in all professional questions in and out of the hospital . . . ?” He believed doctors should be second to no one, even to “those benevolent individuals, charitable organizations or religious societies that founded these institutions. . . . In view of the important relations our hospitals are destined to hold with progressive medicine, is it not about time the professional mind began to dominate in the control of these institutions?” With his own situation in mind as a staff member of a Catholic hospital, Niles argued that hospital boards were content to measure their success and usefulness “by the number of patients treated, the lives saved, and sufferings mitigated in a given period,” and they saw no reason to change their methods or purposes. This stance was inadequate to Niles, who measured success in terms of scientific advances. The hospital’s power was “as a promoter of medical progress . . . in the cultivation of a spirit of scientific investigation and in furthering the efforts of good men to advance medicine.”

Led by Niles, in 1903 doctors at Holy Cross Hospital tried to recast the institution to fit their own professional goals. They specifically wanted the hospital to be distinguished as a scientific institution that would rival the Mayo Clinic in Minnesota. They discussed printing a bulletin to advertise their work: “There is a selfish motive in all this. . . . The bulletin would show the outside world that scientific work is done here—not all mercenary and when they receive that impression it will redound to our
and the Institution’s benefit.”Hinting at possible objections to their move by the superior, they continued, “Not that there would be any immediate results,” but they should “agitate” for these matters and “report and suggest from meeting to meeting.”

Some doctors felt threatened by newer institutions in the local community. In 1897, doctors at St. Joseph’s Infirmary in Fort Worth feared competition from a new Catholic hospital being built in nearby Dallas, one that might attract patients from Fort Worth if St. Joseph’s did not have similar facilities. Dr. W. A. Adams wrote Mother St. Madeleine:

No doubt you have heard of the elegant infirmary which is being constructed in Dallas by the Sisters of Chicago. It is a fact... that our hospital here is very inferior, especially that feature which lacks to the comfort of private patients... [W]e would dislike very much to have it said that Dallas had a superior hospital to Fort Worth.

These statements hint at the sisters’ resistance to the costs of modernizing their hospital facilities. They worked hard and long to develop their operational budgets, so it was important for them to foresee a clear return on each new capital investment. Since they believed patients already were being well served with the existing equipment and facilities, they needed to be convinced by local medical authorities of the need to update and modernize. Not long afterward, to maintain their competitive edge with other hospitals, the Incarnate Word Sisters did add more private rooms and updated facilities to St. Joseph’s. And sisters at Holy Cross Hospital and elsewhere spent hundreds of thousands of dollars to renovate their buildings and bring them into line with scientific standards. Complications arose if doctors emphasized only medical and scientific functions and dismissed nuns’ religious frames.

When Holy Cross Hospital superior, Sister Lidwina Butler, died in 1913, the outpouring of support at her funeral was a broad affirmation not only of her status in the community but also with physicians. Despite previous conflicts, eight doctors served as pallbearers.

Negotiation Strategies

In their letters and dealings with physicians and businessmen, many sister-superiors clearly saw themselves as equal partners and deserving of respect. Whether writing to get the lowest rates for railroad passages or working with physicians, their letters reveal confidence. In 1901, Mother
St. Madeleine of the Incarnate Word Sisters had the self-confidence to insist on autonomy for her sister-nurses when they negotiated a contract to work as nurses in another hospital in St. Louis, Missouri. Unlike the sisters’ own hospitals, the St. Louis facility was a physicians’ project. Rather than inviting doctors to join the staff, as the nuns had done at Santa Rosa, the sisters found an organization and staff already in place. To their dismay, the sisters did not have any control over admissions or price setting. After being informed that a board of directors had to approve any decision taken by the sisters in setting fees, Mother St. Madeleine wrote the physician in charge:

Must we infer from this that for every patient admitted we must ask the board to agree with us as to the compensation to be given the hospital? If so the Sisters would have no freedom, and it would be very difficult to manage matters. However, we rather think that your meaning is to agree with us as to general prices, but that you will leave the Sisters free to make the financial arrangement with patients in what concerns the hospital services, exclusive of the Physicians’ account.

She wanted the freedom to admit patients that physicians might not approve, because “it occurs to us that cases might come up which we would find it hard to refuse.” She was able to make her point, because in a later letter she wrote, “[W]e are pleased to know that we misunderstood you as regards the first point. Concerning the second, I think we will have no trouble.”

Four years later, however, Mother St. Madeleine disagreed with a physician over his management of the sisters, and she promptly pulled them out of the Missouri hospital. She wrote:

We are perfectly willing that our Sisters devote themselves to the care of the sick and suffering, but it is our duty to see that [the sisters] are treated with justice and respect. . . . It is not reasonable that they be interfered with by other officers, in a manner to prevent them from getting the necessaries for food, etc. for the patients.

She then chastised the physician for refusing the sisters any paid vacation time: “Must our Sisters be treated as mere mercenaries?” She hastened to add, “It is not for the paltry amount that we claim redress, but for the principle.” She based her decision to remove the sister-nurses on the ground that “their services are asked for in many other places where they will receive the respect and deference due their calling.” Mother St.
Madeleine built her argument in a way that reinforced the sisters’ religious vocational status. When she began, she acknowledged the sisters’ willingness to devote themselves to the care of the sick, but she clearly expected them to be treated with the respect they deserved. Their services were always in demand in other dioceses.

At other times, superiors simply dictated their wishes to physicians, knowing that they would be respected. Regarding another hospital, Mother St. Madeleine wrote to Dr. C. A. Smith: “We do not consider that our Sisters receive sufficient remuneration for their services as nurses. . . . You will certainly agree with us, dear Doctor, that the Sisters should at least receive more than ordinary workmen.” This quality of decisiveness defied gender stereotypes of appropriate models for females.

Still, nuns had to deal with tensions between the independence they exerted in administering hospitals and the traditional beliefs of women’s subordinate position in church and society. In interacting with the non-Catholic and male communities, nuns were in a weaker position. To cope with these tensions, sisters often downplayed their achievements or presented them as motivated by self-denial and self-abnegation. Sometimes this involved presenting a humble, composed demeanor that was very much in line with religious prescriptions for their behavior. In their communications with others, they often used traditionally “feminine” means such as humility and politeness. Father Dennis Kiely of Salt Lake City recalled that Sister M. Holy Cross Welsh’s “humility would disarm criticism. She was patient beyond endurance.” And sisters used the weapon of tact, particularly in their efforts to break down anti-Catholic fears. Other tactics complicated gendered depictions of communication strategies. While sisters often sounded very polite and avoided inflicting their mind or views on others, at other times they imposed their claims on physicians and obtained agreement on issues of hospital policy.

Some may interpret nuns’ actions as manipulative, with sisters feigning charm to garner favors. Others may see superiors’ letters as “linguistic marks of subordination,” a term used by James C. Scott in his analysis of power conflicts between dominant and subordinate groups. Manners can be an expression of power. Subordinates may appear deferential and amiable, but in reality they are actively resisting power and appropriating flattery and deference to achieve their own ends. Evidence suggests that power was inherent in sisters’ manners and humble discourse. Despite its apparently benign appearance, this power was extremely effective in fashioning sisters’ identities and behaviors. As they drew on their religious roles, they conveyed a mode of selfless decision making. Had others seen sisters as asking favors for themselves alone, they likely would not have
obtained them. As humble and gracious nuns, they could obtain certain courtesies or refuse secular direction without being seen as prideful or rebellious.

For example, in 1900, Mother St. Madeleine wrote a railroad executive: “We ask this in the name of charity and love for suffering humanity, as you are aware, kind sir, that our only resources are the labor of our hands in the service of the sick and the care of the poor.” Thanks in large part to their gracious attitudes, sisters often received reduced rates for railroad travel, or they obtained rebates to ship freight for hospital construction. Indeed, by projecting an image of self-sacrifice and humility, they were less threatening to males and thus able to accomplish more. The notion of power through meekness was a strategy that Catholic women in active religious communities successfully employed throughout the nineteenth and early twentieth centuries. Still, they conceived of their work not in terms of power but of service. In caring for the sick, they were doing God’s work rather than their own. Thus, even though it involved authority and power, to the sisters it was a ministry.

**Relations with Bishops and Priests**

The fact that the sisters and clergy were all Catholic should not obscure the drama of sisters’ means of resistance to hierarchical authority. In 1901, a Salt Lake City newspaper article reported “that the independence of the Holy Cross [Hospital] has been emphasized at various times, causing the bishop to feel that its management does not wish to be identified with and subordinate to the local church authorities.” The bishop in question was Lawrence Scanlan, quoted at the beginning of this chapter. His lack of appreciation of the Holy Cross Sisters’ show of independence was based on the hierarchical organization of the Catholic Church over women who were mere nuns. The Irish-born Scanlan epitomized the authoritarian cleric who had been empowered by the increased centralization of the church in Rome since the mid-nineteenth century. Furthermore, edicts dating back to the sixteenth century and the Council of Trent had given bishops the right to sanction enterprises in their dioceses. What proved problematic for Scanlan was that the sisters’ congregation in South Bend, Indiana, owned Holy Cross Hospital, making it outside his jurisdiction. Furthermore, the sisters had constitutions with papal approval and legal contracts that protected them from the diocesan administrator’s control. Bishop Scanlan also objected to the fact that most of the medical staff consisted of Protestants and Mormons. Hence, he favored a second
Catholic hospital, one that would be more responsive to his authority.60

In 1910, Bishop Scanlan helped establish Judge Memorial Home and Hospital, a Catholic institution run by the Sisters of Mercy. This women's order had been founded in Ireland in the 1840s and was not centralized. The sisters worked for local dioceses, leading bishops and priests particularly to favor them. Their facility in Salt Lake City served not only as a home for aged and infirm miners but also as a place where patients could receive medical and surgical treatment. The hospital closed, however, in 1915 due to a lack of patients and the realization that Holy Cross Hospital was adequately serving the community.61 As this example shows, nuns' hospital administrative roles sometimes brought them into conflict with ecclesiastical superiors, even though women religious were supposed to be models of obedience and unassertiveness. Feminine qualities, which the Catholic Church cultivated, made nuns the ideal teachers and nurses. When their activities involved administrative functions, however, which were male roles, clashes with the hierarchy were more apt to ensue.62

The paternalism of the Catholic Church limited sisters in how much influence they had over church policies. Specific religious practices and obligations, including hearing confessions and saying Mass on Sunday, required a priest, and the local bishop chose the chaplains. Many sisters learned how to use this relationship with the bishop to their advantage.63 While the church hierarchy had ultimate authority in appointing chaplains to the hospital, sisters could circumvent episcopal choices by providing room and board for visiting priests whom they respected, in exchange for Mass and confessions. Sisters often utilized the services of visiting clergymen, or even patients who were priests, to augment their spiritual lives. In May 1896, Father E. J. P. Schmidt said Mass for the sisters at Santa Rosa Infirmary. After spending some time there as a patient, he returned to his home in Indiana, prompting several sisters to write him to return for a visit. Sister M. Gabriel wrote, “It is needless to tell you that Rev. Mother and all would give you a hearty welcome.”64 Thus, encouraging visiting clergy to call on the sisters and stay in their hospital was a means of obtaining priests of their own choosing.65 Other records reveal a more complicated relationship with priests and bishops than these examples of resistance show. Some sisters showed heightened concern over episcopal approval, while others had very positive relationships with the clergy.

Even though nuns served as hospital administrators and trustees and operated from a position of power and autonomy, in later years many ecclesiastical leaders still maintained that sisters represented the feminine ideal. In 1928, Father Edward Garesche, founder of the International
Catholic Federation of Nurses, described the sister-administrator as radiating “sweetness and charity,” whose “associates work with her in charming concord.” While Father Garesche was bestowing this lavish praise, sister-administrators were quietly and efficiently exercising their sizeable administrative authority, no doubt aided by their comforting feminine attributes.

Nuns’ work as nurses and hospital administrators shows the interplay of religion, gender, and power. Their status as women religious gave them legitimacy and a pivotal role in hospital activities. Furthermore, sisters’ papally approved constitutions protected them from diocesan religious leaders’ control. While compromise was the solution to most of their problems, nuns also organized and collectively resisted the authority of both physicians and clergy who tried to limit their activities. For their part, physicians and priests usually respected the sisters’ authority.

Because church and societal prescriptions imposed constraints on women, nuns often used the language of obedience, humility, and self-effacement to fashion a public presentation of themselves. This positioned them within more acceptable cultural norms and convinced physicians and ecclesiastical superiors that their work was beyond reproach. The picture drawn here is a complex one of nuns who were not only demure and submissive but also decisive, capable, and even stubborn at times. Those who employed such bold strategies successfully, however, had to follow two unspoken guidelines. First, when they stepped beyond traditional gender roles, they had to do so, not for self-serving purposes, but to ensure that just and humanitarian causes were upheld. Secondly, they had to have earned the right to be assertive by having lived the lives of proper and well-respected nuns.