Addressing the Times:

NUNS AND THE STANDARDIZATION MOVEMENT

We cannot help asking where now are the faithful nuns, those “angels of the battlefield” who taught the world how to nurse. . . .

So much maligned, yes, even by some of our nursing journals. . . .¹

A Sister of St. Francis

February 1907

In this letter to the editor of a secular nursing journal, a sister protested the disrespect many felt in the early decades of the twentieth century. Rather than relying solely on their own autonomy to set up and manage their hospitals, nuns had to deal with external factors such as the professionalization of nursing, the Flexner Report, and the American College of Surgeons. Sisters carried an additional burden. They were religious women who were unfamiliar to many people when they first arrived on the American scene. Their gender traditions differed from Protestants: nuns had voluntarily taken the religious vow of chastity, and they wore habits that were distinctive to a woman’s religious order. One layman voiced a common view that they lived “more or less secluded lives, quite apart from the world and under conditions quite peculiar to themselves—lives of service given almost solely to the care and comfort of the sick and ailing.”² Sisters also were part of a Catholic tradition still trying to earn respectability. Added to perceptions about them was the growing anti-Catholicism that had resurfaced in the 1890s. Though their nursing dur-
ing the Civil War helped lessen prejudice against them, hostility toward Catholicism had increased when immigrants from southern and eastern Europe poured into the country. Many Americans saw sisters as representatives of the immigrants’ church. These images, along with the widespread idea that Catholics were a threat to democratic institutions, set nuns apart as “outsiders.” This “outsider” status influenced their adaptation to changes in nursing and medicine.

The Catholic Hospital Association: A Sisters’ Organization

The most important influence, however, was the hospital standardization movement. The American College of Surgeons (ACS) organized in 1913, and by 1917 it had adopted minimum standards for hospital approval. Hospitals had to have an organized medical staff with monthly meetings to discuss cases, a sufficient laboratory for proper diagnosis, and a sophisticated system for record keeping. It was at this point that physicians obtained more authority in hospital decision making, particularly those involving staffing.

To keep pace with the hospital reform movement, fourteen Sisters of St. Joseph of Carondelet met with Father Charles B. Moulinier, regent at Marquette University Medical School, in Minneapolis in 1914 to discuss plans for a Catholic organization that would ensure the highest hospital standards. The Catholic Hospital Association (CHA) was formed the following year, with Father Moulinier as president. At the first CHA convention in June 1915, two hundred sisters, physicians, and lay nurses representing forty-three hospitals attended. The CHA was a powerful constituency in supporting the ACS’s efforts at standardization, and in 1918 it approved the ACS’s plan for Catholic hospitals. The ACS began inspecting hospitals that year, and by the early 1920s it had approved most of the institutions represented in this book. Some hospitals, such as St. Mary’s, Cairo, and St. Joseph’s, Fort Worth, did not receive approval until the sisters constructed new buildings. New standards determined by a secular agency threatened nuns’ control over their hospitals. Neither they nor other Catholic leaders had helped formulate the ACS plan. On the other hand, because Father Moulinier was a member of the ACS standardization committee, which involved actual hospital inspections, Catholic hospitals could be protected from any strong secular control and generally were.

Father Moulinier favored a sister for president of the CHA, but conservative bishops and priests opposed him and prohibited nuns’
appointments as full-time officers. Priests held the highest leadership positions until the 1960s. Sisters, however, served on the executive board, headed committees, participated in conventions, and set standards for Catholic nursing education. Two members of the Sisters of St. Joseph of Carondelet especially were active. Sister Esperance Finn, superior at St. Mary’s Hospital, Minneapolis, was one of the founding members of the CHA and served as second vice-president from 1916 to 1919. Sister Madeleine Lyons was a member of the national executive board from 1921 to 1924 and became the first president of the CHA’s Minnesota-North Dakota Conference.

At the 1916 CHA convention, Sister Esperance presented a paper on the nuns’ contributions to team work in Catholic hospitals. Emphasizing cooperation, she focused on their relationships with physicians and hospital chaplains. The physician was the “director of our team-work” whose medical orders should be supported. The chaplain held the highest honor, however, since he stood for the patient’s “spiritual interests, which we sisters are eager to promote.” With typical humility, she did not discuss the nuns’ authority in hospital management, but Father Moulinier did. He pointed out that nuns had an advantage over other hospitals because of their “closer control of the situation. It lies entirely in the hands of sisters of Catholic hospitals to manage” their institutions’ affairs independent of any managerial boards. In his President’s Address at the 1918 convention, he affirmed that the CHA was the sisters’ organization. He clarified, “It is not the clergy’s; it is not the doctor’s. I am going to say it is not even the hierarchy’s.”

Not all agreed with Father Moulinier’s identification with the ACS. A conflict occurred at the 1921 CHA convention when a group of physicians tried to separate the Catholic organization from the ACS. They claimed that the college was determining policies for Catholic hospitals as well as for physicians. To avert this challenge, Father Moulinier supported an amendment to the constitution, proposed by a sister, that the voting power for conducting the business of the CHA be left to the institutional membership. By this amendment, the religious communities holding the votes for each member hospital obtained control. The structure allowed sisters to circulate the issues they thought important. Nuns also dominated the committee membership and chair positions. By 1921 the individual membership in the CHA totaled 1,290, with sisters holding sovereignty. (See fig. 8.1.)

Nevertheless, the ACS’s standardization plans called for greater physician control over medical staffs, and by the 1920s internal redistributions of power were beginning to take place. Doctors wrote constitutions and bylaws spelling out the relationship between the medical staff and hospital
administration and specifying procedures for staff selection. At Catholic hospitals, physicians established boards of governors and other committees to advise sister-superiors in these matters. While doctors obtained some power to select their own colleagues, superiors still had final approval of all recommendations from medical staff committees. By 1919 physicians at St. Joseph’s Hospital in St. Paul had formed an advisory board. According to its 1921 constitution, the superior made all staff appointments from names recommended by the board. In this case, the board considered itself an executive committee to be “consulted on all matters of general policy in respect to the conduct of the affairs of the Hospital and Staff.” The St. Joseph Hospital Corporation, however, reserved the right to make final decisions in all such matters. Other Catholic hospitals had similar policies. Sisters continued to comprise their own boards of directors through their hospital corporations, and it was not until the 1960s that lay boards were appointed.
In 1929, the superior at Holy Cross Hospital in Salt Lake City was still a full participant at physicians’ staff meetings. On April 1, she reported that a physician had performed gallbladder surgery on a patient without proper diagnostic foundation. The patient had been admitted with angina and a positive Wasserman test. The superior and the governing board together decided that the physician should be reprimanded and supervised until further notice. She also chastised some doctors for their negligence in completing their charts. In doing so, she was acting under the authority given her by the CHA in 1918 when it approved the ACS’s standardization plan. The CHA had stipulated that member hospitals establish an adequate case record system with a sister in charge. She was to have full authority to demand careful cooperation among physicians, interns, and nurses. Hence, the superior at Holy Cross Hospital instructed the secretary of the board of governors to write to two doctors in particular that “they should complete their charts at once.” The physicians complied.

Case records, particularly patient histories, were often problematic due to physicians’ time constraints. To deal with these matters, sister-supervisors shared ideas at roundtable discussions at national and state CHA conventions. (See fig. 8.2.) Rather than “spanking the doctors into line,” as one superior put it, she had a nun trained to take histories while physicians did the physical examinations. Other superiors invited representatives from the ACS to talk to staff physicians.
Transitions to the new system were not always smooth. A conflict relating to the standardization movement occurred between physicians and the Congregation of the Poor Sisters of St. Francis Seraph of the Perpetual Adoration at St. Anthony’s Hospital, Terre Haute, Indiana, which the sisters had established in 1882. In 1920, the nuns hired Dr. J. J. Moorhead from Chicago as chief of staff to bring the hospital into line with ACS standards. His changes were problematic for some of the other staff doctors, and twenty-six threatened to resign if the sisters did not remove Moorhead. The hospital superior made it clear that Moorhead would be retained as chief for one more year, prompting the physicians’ mass resignations on January 1, 1921. Only eight doctors remained on staff. Notably, the hospital received the ACS approval later that year. Over the next several months, the sisters encouraged the physicians to return, but they would agree only if they could elect their own chief. The acting hospital superior, Sister Ida Theno, supported the existing head, chosen by the physicians who currently comprised the staff. Newspapers referred to her as “a fighter from Fightersville” and said that “fear of physicians, individually or collectively, is unknown to Sister Ida.” The superior general of the congregation traveled from Lafayette to Terre Haute to mediate the dispute, heard the different stories, and affirmed that the insurgents would not be recognized as a group. She allowed them to return as individuals rather than as a body, which they refused to do. The hospital suffered significantly because of the small number of doctors, and it was not until 1925 that a new superior successfully reorganized the medical staff.

The Attraction of Scientific Medicine

Despite the tendency to see medical science and religion as mutually exclusive, an early goal of the CHA was to synthesize the two models. One way they sought to maintain economic leverage in the hospital market was to identify their institutions with scientific practices. Scientific medicine influenced the demand for medical services, and after 1900, hospitals throughout the country began marketing themselves in terms of scientific fashions of the times. Trade journals for physicians and hospital administrators provide interesting illustrations of these concerns. Reflecting the theory that germs transmitted disease, hospital supply firms suggested that hidden dangers could be found in furniture, bedding, and floors. One ad stated that in hospitals, “where sanitation is one of the principal problems, every crack in a floor is a lair for a mass of death-dealing microbes.” Thus, they needed wood floors specially treated that left the floor impenetrable.
to germs and “perfectly sanitary.” Henry B. Platt advertised his disinfectants to both Catholic and non-Catholic hospitals by featuring pictures of secular nurses as well as sister-nurses.

Antisepsis and eventually asepsis decreased hospital mortality significantly, especially for surgical patients, and in the late nineteenth century, physicians began to perform aseptic operations in increasing numbers. To gain the trust of surgeons and paying patients, sisters’ institutions had to provide reassurances of their safety and success. Thus, advertisements guaranteed physicians, prospective patients, and visiting committees that hospital personnel would practice scientific medicine.

Like other administrators, nuns fostered the image of science and technology in their hospitals by having pictures of operating rooms, laboratories, sterilizers, and other equipment as illustrations in their annual reports. In the early years, physicians often donated the equipment. Such celebratory publications usually showed the idealized version. Advertisements emphasized gleaming tiled walls, sanitary operating rooms, and the newest x-ray equipment. A 1914 newspaper in Salt Lake City described Holy Cross Hospital’s most recent addition that included “the very latest in the most advanced systems.” It had an entire floor devoted to an operating room, sterilizing and recovery rooms, x-ray department, and laboratory, all with the “highest type of sanitary arrangement and furnishing.” By the early twentieth century, pharmacies had also enlarged and modernized. Annual reports also touted new services and equipment. The 1912 annual report for St. Joseph’s Hospital in St. Paul pictured two white-clad nurses with physicians in dress suits leaning over a patient on the floor, and a Draeger pulmotor prominently displayed. The report noted the lifesaving benefits of this new technology: it was for “resuscitation in accidents in the latter stages of gas poisoning and asphyxia of the new born.”

In smaller communities, similar developments occurred. In 1890, Dr. W. W. Stevenson of Cairo, Illinois, proudly described St. Mary’s Infirmary as a first-class hospital that had the “comforts of a home.” Revealing the juxtaposition of science and homelike comforts in this period, in 1910 newspapers also proclaimed St. Mary’s “superior advantages in the way of modern improvements, medical and surgical attendance.” It had an x-ray room, “perfectly equipped operating room,” and laboratory.

Headlines also noted world-renowned doctors doing surgery in Catholic hospitals. For example, in 1902, the Salt Lake Tribune announced that Professor Adolph Lorenz from Austria had performed surgery at Holy Cross Hospital on a patient with congenital hip dislocation using
the “knifeless” method of reduction. This statement assumed that prospective patients would be impressed not only with the surgical procedure but also with a European physician.

Leaders in the CHA were particularly interested in Catholic hospitals becoming advanced in medical science and education. Among the purposes of the organization, stated in the constitution adopted in 1915, was to promote “scientific efficiency and economy in hospital management.” Complying with ACS standards, nuns added pathologists, laboratory specialists, and radiologists to their hospital staffs. After William Roentgen’s discovery of x-rays in 1895, x-ray departments were essential for any hospital caring for acutely ill or injured patients, and physicians often donated the initial machines. But just who was going to control the machine became a central question both inside and outside hospitals. Sisters received training as x-ray technicians and headed their own departments. After Dr. W. S. Hamilton started the x-ray department at Santa Rosa Infirmary in 1912, Sister Clara Kalbfleisch obtained certification as a technician and operated the machine. By 1924, a survey of
over a hundred Catholic hospitals revealed that eighty-two had a sister in charge of the department, while seventy-eight had a “physician roentgenologist” who read and interpreted the films. In other hospitals, patients’ individual physicians did this task.34

What sisters actually thought about this increasingly technical aspect of medical care can be inferred from Father Moulinier’s President’s Address to the 1918 CHA convention. Using both scientific and service rhetoric, he stated, “We never lost sight of the great fundamental, ethical principle that the patient has a right to all the most enlightened, self-sacrificing, scientific, philanthropic, and conscientious religious service that body, mind, and soul of man . . . has a right to.” Significantly, he added, “We repudiated any such thought that the hospital is a mere boarding-house, a place where the surgeon merely operates, where the internist merely prescribes medicine or treatment . . . .”35 Rather, it was their sacred obligation to provide the best possible service to the sick. Hence, while they accepted scientific advances, hospital leaders tried to prevent an emphasis on technology from being the overriding factor in their work.

Regardless of such admonition to keep the human element a vital aspect of hospital service, scientific procedures and technologies continued to advance. And to keep pace with those developments, Catholic hospitals expanded their clinical teaching facilities. As part of that instruction, physicians campaigned among sisters and CHA leaders for the opportunity to do autopsies. In many ways, the nursing sisters, with their spiritual identities clearly established, stood in direct contrast to the impersonal nature of medical technology. It was pivotal, then, that to promote the importance of scientific advances to the general public, the sisters themselves join in that promotion. In a 1923 *Hospital Progress* article, Dr. Charles A. Gordon tried to convince them of that marketing strategy by arguing that the “Great Physician” gave authority for scientific research. He also used the language of competition: the time “has come when we must make a determined effort to increase our autopsy efficiency or fall behind in the hospital race.” In getting family acceptance of autopsies, Gordon stressed that a “tactful Sister or two, well armed with information, may solve the problem; their apparent disinterestedness may carry the day.”36 During the 1920s, at least some Catholic hospitals complied. Fort Worth’s St. Joseph’s Infirmary, for example, had the entire fifth floor reserved for operating suites, treatment rooms, and an autopsy room (morgue) (fig. 8.4). The 1927 *Souvenir Book* published upon the dedication of the new addition noted that the autopsy room was “an important aid to scientific research.”37
New Standards in Nursing

While some women’s religious congregations resisted modernization and attacked ACS standards, other communities supported them and pushed for more education in both nursing and hospital administration. Premodern nursing before 1870 consisted of administration of simple medications, maintaining cleanliness and safety, providing nourishment, and giving spiritual care, but after the turn of the century sisters specialized in one kind of work. Some nursed at the bedside or had charge of the surgical supply departments and medical and surgical floors, while others trained in pharmacology. Sister Cuthberta Chawke of the Sisters of St. Joseph registered as a pharmacist in Minnesota in 1915; and in 1918, Sister Cordelia Gahagan of the Sisters of the Holy Cross was the first woman to become a registered pharmacist in Utah.38

Particularly significant for nuns was nursing leaders’ crusade to separate the trained from the untrained nurse. As nursing evolved from a service to a trained practice and scientific and technological advances developed, a good nurse came to be measured not only by her character but also by her technical competencies, knowledge of disease prevention, discipline, and organization. Nuns responded to these challenges and updated
their practice through establishing their own nursing schools that emphasized scientific knowledge and expert training.\textsuperscript{39}

After the turn of the century, sisters began adapting their clothing to meet scientific standards, although this created considerable controversy. The religious habit represented a nun's devotion to her particular order, and any changes had to be approved by either the bishop for diocesan orders or the Vatican for papally approved congregations. For many, this change in habit did not come about until the 1920s in response to the standardization movement. Discussion at that time centered around sisters wearing white washable habits while on duty instead of black woolen ones which, in the eyes of some medical authorities, harbored germs. Sisters addressed the issue at special CHA conferences. One nun expressed concern that they would compromise their religious identities and “think less of our habit if not given to us so often. When we received this religious habit, we were so happy. . . .”\textsuperscript{40} Yet, another sister wrote, “[T]here was in these controversies a surprising display of lack of common sense and a superabundance of rule,” and she called for modification of community rules.\textsuperscript{41} Often, sisters wore the full black habit and a white gown over it, while others wore white habits only in certain instances. In all cases, nuns maintained their religious distinctiveness by wearing symbols such as crosses.

Some nursing orders began adapting their religious habits earlier. In November 1897, sisters at Santa Rosa wore white veils for the first time during an operation and had white caps made for the doctors.\textsuperscript{42} In figure 8.5, a newspaper photograph taken in the early 1900s at Santa Rosa, sisters are wearing white aprons and sleeves over their black habits.\textsuperscript{43} A nun who entered training at St. Mary's Hospital, Minneapolis, in 1910 became a surgical nurse and designed her own uniform: she pinned up her black skirt and sleeves under a white doctor's gown and wore a white outer veil over the black one.

Figure 8.5 is conspicuous for another reason: it shows the presence of sisters standing in the operating room as if they were overseeing the procedure. The photo appeared in the local San Antonio newspaper, and the message conveyed seems clear: that the nuns were an integral part of the hospital's professional services. Indeed, the feature that distinguished Catholic hospitals from their non-Catholic counterparts lay not in their identification with scientific medicine but in the hospital's sanction by women religious.

At the same time, some physicians, such as the Protestant S. Weir Mitchell, publicly criticized sisters' lack of training, and even Catholics expressed concerns.\textsuperscript{44} Speakers at CHA conventions—priests, nuns, and
physicians alike—extolled the need for more training. In 1923 Father Moulinier lamented that, in religious communities where both teaching and hospital work were done, the teaching sisters had preference in education because of the Catholic Educational Association’s influence. This resulted in less education for hospital sisters. He noted that with few exceptions, sister-nurses were eager for education, but often hospital superiors could not spare them to give them the education they needed.45

Still, the constitution of the CHA reiterated principles espousing higher education for nurses, and sisters became leaders in the association’s education movement.46 Two members of the Sisters of St. Joseph from St. Mary’s Hospital, Minneapolis, did postgraduate work in nursing education and administration at Columbia University in 1915. Another, Sister Conchessa Burbidge, a registered pharmacist and administrator, was instrumental in helping to establish a summer school at Marquette University, which offered seven different courses. Sixty-nine sisters from different congregations attended in 1916.47 By the 1930s, some nuns were
taking graduate courses at Catholic University’s School of Nursing Education and at Marquette’s Hospital College, one of the country’s earliest academic hospital administration programs.48

More Tensions with Physicians and Clergy

Conflicts over Nursing Education

Sisters’ work in hospital administration countered male dominance in that field, and their training schools solidified their authority with students. These factors also enhanced nuns’ influence with physicians. In many non-Catholic hospitals, doctors formed schools of nursing to meet their own objectives, thus undermining the nursing superintendent’s control.49 By contrast, nuns kept control over financial management and student training in their own schools. The superintendent of the nursing school, a sister, was responsible to the hospital superior, not to a nonnursing board of trustees.

The training schools did not function entirely independent of physicians. Doctors supported nursing education and, in fact, became presidents at Santa Rosa, San Antonio; St. Joseph’s, Fort Worth; and St. Joseph’s, St. Paul. A 1905 constitution for the Santa Rosa Training School listed committees of physicians who, along with the sister-superintendent and hospital superior, established entrance and graduation requirements, selected faculty members, and determined course work. The doctors, however, had to apply for the privilege of teaching the students. If they missed three lectures, the superintendent of the training school informed them of their dismissal from the faculty. One of the first graduates of the Santa Rosa Training School was Sister Robert O’Dea (fig. 8.6). In 1919, when she became hospital superior and superintendent of nurses at Santa Rosa, she curtailed some of the doctors’ control of the training school by insisting that the dean, a physician, consult with her before presenting any problems to the medical faculty. She also required physicians’ applications for and resignations from the faculty to first come to her. Physicians protested, believing that peer review should be their prerogative. Undeterred, she continued with her plan.50 By 1920, a few sisters from other congregations were advocating for secular boards for their training schools, but only if the hospital superior approved the membership. Efficiency would be improved, they felt, but board members should not conflict with the obedience due superiors.51
In training young sisters and secular nurses for their work, most nuns saw themselves as the very best instructors. They asserted that, along with theoretical work and practical training, the teaching of moral and religious instruction should be characteristic of all Catholic nursing programs. This was difficult due to competition with other training schools, many of

**FIGURE 8.6** Left to right, Incarnate Word Sisters Philip Neri Neville, de Sales Keegan, and Robert O'Dea were among the first graduates of the Santa Rosa Training School for Nurses in 1906. (Courtesy Archives, Motherhouse of the Incarnate Word, San Antonio, TX)
which the sisters considered too lax. Likewise, the “pleasure-seeking tendency” of the time was problematic. With nuns’ good example, the religious atmosphere of the Catholic hospital, and a daily routine, however, sisters did not doubt their eventual success.52

While nuns held a measure of authority in their training schools, some church leaders hampered their autonomy. In the CHA, priests preoccupied themselves with concerns over whether sisters should attend professional meetings, take courses in secular institutions, obtain obstetrics training, and join secular nurse accrediting agencies such as the National League for Nursing Education (NLNE).53 Religious rules forbade some sisters from serving in secular organizations, but other nuns were not so restricted, and they were both members and officers in state and national associations. By the early 1930s, more than three hundred sister-educators had joined the NLNE. They formed the Sisters’ Committee within the league to enhance cooperation and to provide a Catholic influence. Yet some CHA leaders doubted the NLNE’s neutrality in accrediting sisters’ programs. Father Alphonse Schwitalla believed in “the sacred character of the hospital . . . and the inherently conventlike” atmosphere of Catholic nursing schools, which “precluded a secular agency’s evaluation of Catholic nursing education.” Eventually the CHA formed its own organization, the Council on Nursing Education, which began accrediting Catholic agencies in 1934. This was a contested issue among nuns, however, as some chafed at the association’s separatist stance.54

Sister Conchessa Burbidge was a moderate on the NLNE issue. She articulated the sisters’ majority opinion: the CHA accreditation plan guaranteed “that we shall be free to teach and to practice our own Catholic doctrine and follow principles with which we are heartily in accord.” This translated into a safeguarding of Catholic attitudes in the education of nurses. Sisters could carefully guide students according to their own understandings of what nursing should be.55

Conflicts over Nursing Practice

In their 1907 history of nursing, Adelaide Nutting and Lavinia Dock asserted that European nursing sisters’ practices “gradually declined” after the early nineteenth century, in that they “have not been allowed to share in the advance of medical science.” The authors blamed clerics for hampering sisters’ education by preventing them from witnessing childbirth or caring for parturient women. Nutting and Dock had less harsh words for sisterhoods in the United States, who more readily adapted to modern medicine.56 Yet, even nuns in this country had to engage in subtle negoti-
ations when taking on nursing services in troublesome areas. Some religious prescriptives that forbade nuns to nurse in operating or delivery rooms created a particularly problematic situation. This likely was related to the modesty requirement for chaste women. In seventeenth-century France, Vincent de Paul worried that scandal would occur if sisters were involved with laboring women and warned them not to care for women in childbirth. At that time, nuns were excluding pregnant women and nursing mothers from their hospitals in order to uphold the moral integrity of their communities. Women who typically delivered babies in hospitals were unwed mothers or those without decent homes. Sisters worried that opening their hospitals to such women could hurt the institution's reputation and could cause problems with other potential admissions and with benefactors. Furthermore, women who delivered in hospitals rather than homes might be infected with venereal disease.

In Revolutionary France in the late eighteenth and early nineteenth centuries, well-trained midwives delivered babies in hospitals such as Paris's Hotel-Dieu, where Augustinian nuns were the nurses. Immediately after birth, the mothers would return to the general wards. In 1814, at the time of the first Restoration in France, the nuns took over more control of hospital administration and insisted on separating maternity services from infant services, on the grounds that “innocent babies” should be separated from their “sinful mothers.” Then, in 1901, the papal document *Normae* forbade sisters to work with maternity cases. While it was not formally promulgated until that year, it represented ideas that were widely held prior to that time.

Other factors had to be considered in America in the nineteenth and early twentieth centuries. Catholic sisterhoods were not spared vitriolic contempt from nativism. Both priests and sisters were extremely sensitive to anticonvent discourse that included shocking tales of “unrestrained sexuality” within convent walls. Some critics considered the idea of autonomous women avoiding their procreative duties as dangerous to the natural, patriarchal order. These threatening perceptions persisted in spite of the fact that nuns' nursing and teaching actually conformed to traditional domestic ideologies of the times.

Orders founded in the United States during the nineteenth century or those that had separated from European motherhouses were more likely to adopt modern methods of nursing. An 1899 textbook for sister-nurses, written by a priest for the sisters at St. John's Hospital in Springfield, Illinois, detailed the nuns' responsibilities while assisting physicians in the operating room, giving anesthesia, caring for wounds, assisting with pelvic examinations, inserting urinary catheters, giving massages, and caring for
patients after gynecological surgery. It alluded to the problem sisters faced: during operations, the sister-nurse must especially guard “her eyes, avoiding everything that she is not obliged to see and by all means preserve her dignity and modesty.” She may assist with a bladder operation for male patients, “but only when the doctors are extremely careful.”

In 1908, Vatican officials wrote superiors of nursing orders in the United States to express their concerns about nuns working in operating rooms and caring for men “in things not altogether becoming to virgins dedicated to God.” A superior of the Sisters of St. Joseph in St. Paul responded that the sisters admitted both men and women in their hospitals but did not give massages to patients of either sex or baths to males. Furthermore, sisters took “no part in operations performed . . . leaving the whole work of attendance on the operating surgeons to trained nurses and secular women.” But she discreetly added, “At times Sisters may be found in the vicinity of the operating rooms, so as to see that whatever is needed is duly provided: but in all this nothing is done or allowed that could conflict with the strictest rules of religious modesty.”

Ultimately, the solution that sisters in the United States devised was a careful negotiation of their roles and sometimes even a circumvention of religious prescriptions. And it appears that, at least for the Sisters of St. Joseph, Sisters of the Holy Cross, and Incarnate Word Sisters, American bishops did not strictly enforce Normae. There is no recorded incidence in which they sent priests into hospitals to impose it. Some conservative bishops seemed more concerned with nuns wearing white habits instead of black ones in the operating room, fearing the sisters would appear more secular. Despite Rome’s statements, some of the sisters assisted in surgical procedures, although they likely tried to “guard their eyes.” They also prepared dressings and supervised and maintained aseptic procedures. Early chronicles at Santa Rosa and Fort Worth’s St. Joseph’s Infirmary indicate that two Incarnate Word Sisters regularly assisted surgeons in the operating room, and a sister often administered anesthesia. Other hospitals revealed similar findings.

Nuns circumvented the surgery ban, probably because surgery was such a prominent aspect of their hospitals. Maternity care was more troublesome territory. At that time, midwifery was a complex issue in the United States, and in many places only physicians could work in that capacity. Because of a dual attraction of scientific medicine and increased comfort, safety, and convenience, hospital births became increasingly attractive to middle-class women. For most women, childbirth moved from the home to the hospital between 1910 and 1930. As a result, doctors began agitating for more hospital space for obstetrical cases, and sisters responded.
While Holy Cross Hospital in Salt Lake City recorded only nine maternity cases in 1891, in 1908 the superior agreed to the doctors’ request to receive more obstetrical cases, although she maintained that the women should have special nurses rather than sister-nurses. The nuns recorded forty births in 1908, sixty-three in 1912, and 171 in 1915. The hospital opened a maternity ward in 1916 under the charge of Ella Mae Wicklund, a secular nurse and one of Holy Cross Training School’s top graduates. When she resigned in 1917 to become secretary of the State Board of Nurse Examiners, a sister-nurse who had just completed her training succeeded Wicklund as head nurse. Catholic hospitals eventually opened separate obstetrical wards, typically after World War I, and expanded hospital delivery rooms.

Before the expansion of maternity services, the Incarnate Word Sisters simply adapted to the moment, which often meant ignoring religious stipulations. In 1890, nuns at both Santa Rosa and St. Joseph’s Infirmaries delivered babies when no doctor was present. The sisters did, in fact, obtain the authority to ignore their rules if necessary as early as 1872 in their constitution. By 1906, they had added to their Directory that, although sisters should not attend obstetric cases, “this should not be taken in the extreme, as in many places and cases, circumstances are such that this cannot be avoided.”

Other issues were at stake. In 1913, the sister-superior at Holy Cross Hospital met with physicians to discuss operating room procedures. She expressed her willingness to do whatever she could to satisfy the staff’s wishes, especially with reference to scheduling procedures. But she emphasized that she would not permit “criminal operations” to take place. Other historians have explored the dilemma of obstetric surgery in Catholic hospitals. Joseph G. Ryan has effectively argued that one reason nursing sisters moved into operating and delivery rooms was to assure that the Catholic Church’s sanctions against abortion and the destructive surgery of infant craniotomy would be observed in their hospitals. Indeed, at the 1921 CHA convention, Dr. Emerson Root from Holy Cross Hospital in Salt Lake City posed the question, “How long would a doctor last in a hospital” if he did anything the Catholic Church considered wrong? “There is every kind of check in the hospital... We know that in the operating room the Sister in charge... is just as watchful as anybody could be.”

That same year, the CHA adopted a Surgical Code for Catholic Hospitals, taken from one stipulated by the Detroit diocese and printed in the first edition of Hospital Progress. Specifically, it prohibited operations involving the destruction of fetal life, including craniotomies of a living
child, “curettment of the uterus” during pregnancy, induction of labor before the fetus was viable, and operations on a living fetus in extra-uterine pregnancies. It also prohibited the removal of an undiseased ovary, uterus, and Fallopian tube. The code was revised in later years, and clearer positions on issues of birth control and contraception were delineated. But for the sisters in 1921, tensions over their professional roles continued. By then, more were participating in obstetric nursing. Their authority to nurse maternity patients was enhanced when state boards of nursing began requiring nurse training schools to offer a course in obstetrics to obtain board approval. Official approval did not come from the Vatican until 1936, however, when Propaganda Fide published *Constans et Sedula*, which lifted the ban on sisters performing surgical and obstetrical work.77

Not all nursing orders circumvented the interdiction. The Congregation of the Poor Sisters of St. Francis Seraph of the Perpetual Adoration in Lafayette, Indiana, a community with German roots, is a case in point. The Vatican’s Sacred Congregation for Religious had prohibited obstetrical nursing in Germany.78 Although the first major operation was performed at the sisters’ St. Elizabeth's Hospital in 1895, obstetric patients were not admitted until forty years later after the publication of *Constans et Sedula*. This same congregation had established a nurse training school for sisters in 1897 but did not admit laywomen until 1937.79

Thus, conflicts occurred over sisters’ adaptations to twentieth-century changes in nursing and medicine, and sometimes nuns broke with Vatican prescriptions. It is doubtful that these circumventions were open acts of rebellion, however. Rather, nuns’ actions were pragmatic adaptations that they made to maintain their hospitals and carry out their health-care missions.

The standardization movement drew Catholic hospitals toward common goals with non-Catholic institutions. Sisters and church leaders adapted their hospitals and nursing to bring them into line with secular society by keeping up with modern scientific standards, establishing their own professional organizations, and forming schools of nursing. This legitimized their practice and enhanced their influence with students, physicians, and hospital standardization organizations. Up to 1925, nuns were prepared in technical skills, and they had the authority to teach these skills to their students. Later writings reveal, however, that by the late 1930s and 1940s, when nursing education programs began moving into universities, nuns became increasingly self-conscious about their relative lack of education as more professionally and technically trained employees staffed the hospitals. It was not until 1948 that sisters began the Sister Formation Conference to work for higher education and pro-
professionalization of teachers and sister-nurses. On the other hand, the nuns’ sovereignty in the CHA, their separate professional organizations, Father Moulinier’s influence with the ACS, and the obstacles sisters faced later, such as the Roman Catholic clergy’s attempt to control nursing practice and evaluation processes, indicate a distinct approach to standardization and modernization for sisters and their hospitals.