I want to begin by acknowledging all the people in this room, and especially the Sisters of St. Joseph of Carondelet who, along with Father Charles Molinier, established this organization in 1915. At the first meeting in June 1915, 200 sisters, physicians and lay nurses representing 43 hospitals attended.

The narrator if this film has provided a fitting introduction to my talk today, and I will expand on her words by providing historical perspective and context. A few months ago, Peggy Noonan wrote in the *Wall Street Journal*: "America without the Catholic church would be a poorer, sicker, colder place, and one less likely to continue." Today I add to that statement by asserting that keeping Catholic hospitals is not an ideological position but rather an imperative.[1] I will discuss the relationship between history and Catholic sisters as innovators and disrupters, and I will focus on 3 areas: hospitals, nursing, and health policy. I will stick to chronology as much as possible.

As a historian, part of my role is to explain the intended and unintended consequences of our attempts to solve certain problems, such as the problem of access to care in a crowded hospital marketplace and the tensions created when supposedly deferential nuns established and ran hospitals in the United States. These sisters were in the vanguard of health care reform beginning in the mid to late 19th century. They built institutions and created services for the poor long before the emergence of the modern hospital and scientific medicine. In fact, the

woman-centered, nurse-based entrepreneurship of Catholic sisters had a distinctive effect on the character of today's American health care institutions.

In the 19th century, sisters expanded their health care in the wake of immigration, and 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 that would appeal to a wide audience. As a result, scores of sisters fashioned new religious lives for themselves and developed entrepreneurial activities in the public domain of the hospital.

In my work, I have argued that there are uncomfortable tensions between the sacred and the secular - tensions that still exist – and must be confronted. My work has also addressed tensions between the public and private. And it shows the success of one model of a public-private mix – the work of the Catholic health care system – and how this model has informed health care policy.

I am interested in how women like Sister Ignatius Farley, an Irish immigrant who came to the United States just before the Civil War and worked as a nurse in that war --became this: What you are viewing here are the owners of the Catholic hospitals across the United States in the 1920s. Most of these women were European immigrants, mainly Irish, and most are nurses. When they first arrived on these shores, they had no money. Furthermore, the public face of Catholic authority has always been decidedly male; it is ironic, then, that most Catholic

hospitals in America were established and originally managed by women. They could not count on the Church for aid, yet these sisters did things that the rest of us urgently need to learn, particularly around questions of power, humility, organizational leadership, nursing practice, and transformation.

From the dawn of Catholic hospitals in America, there has been an inherent conflict between the church's spiritual values and the ever-present market realities in which hospitals had to compete. Sisters engaged with both religious and secular forces that impacted health care to underserved, diverse, and poverty-stricken communities in the 19th and 20th centuries, and they became powerhouses in influencing health care.

In the nineteenth century, when the sisters established Catholic hospitals across the United States, they did so within the context of a pluralistic environment. The Catholic Church in the United States was an outsider, an immigrant church that had to forge its legitimacy among the dominant Protestant church and the whole cultural ethos of Protestantism. During this time as well, medical markets were increasing 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 and West as railway and mining centers increasingly attracted single, primarily

immigrant, men who had nowhere to turn when they became ill except to a hospital.

Immigration was doubling the total number of Catholics, and Church leaders sensed that significant Catholic populations existed with inadequate spiritual institutions. This included hospitals. Sioban Nelson situates 19th century sister-nurses in the United States, in contrast to those in France or Ireland, as being subject to Protestant hostility and part of a financially poor Catholic church. Thus, they had to construct a kind of nursing that focused on accountability, innovation, skill, and flexibility. Their institutions had the dual purpose of healing and comforting the sick and the dying, as well as providing spiritual care. In the process, in the turmoil of 19th and early 20th century immigration and social upheaval, sisters contributed greatly to the production of something new—the modern hospital and the modern nurse.[2]

As well, when nuns established their facilities, they did so within a changing environment of how illness was understood and treated. In the early 19th century, patient's own descriptions of what they were feeling, informed by personally meaningful emotional, cultural, and moral understandings, were important to the doctor patient relationship. But by the end of the 19th century, patients' understandings became almost irrelevant. Diagnostic skill narrowed the meaning of illness to what was 'registered on a meter or appeared in laboratory tests.' But

while doctors could more skillfully diagnose a problem, they could not cure most diseases until the second World War and the arrival of antibiotics and other wonder drugs. Doctors could bring relief, but increasingly this was being eclipsed by a narrower scientific orientation and institutional structure of modern medicine.

By contrast, from the beginning of sisters' hospital establishments, they had an expanded idea about illness and its treatment. They certainly accepted the values and orientations of modern American medicine, but they also believed in supernatural causes and treatments based on a longstanding Catholic devotional culture. They developed a space in the United States where a specific, socially beneficial type of care could be provided and purchased.[3] This was both innovative and disruptive. These insurgent sisters brought into being new hospitals with different economic models, and those in which authority depended not on male physicians or Church leaders or state support, but on the ability of women religious who convinced other people to have confidence in the Catholic hospital that they created.

So how did they do this?

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 Emmetsburg, Maryland, founded by St. Elizabeth Seton, to staff the infirmary.

Most women of the day gave nursing care in the home as part of their domestic duties and mainly cared for family members or friends, not strangers. 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.

You may have seen a recent *Life* magazine issue that considered Florence Nightingale as one of 100 people who changed the world. She began nursing in the 1850s and worked with both Protestant and Catholic sister-nurses in England, Germany, and France, but her experience as a nurse was relatively slight before the Crimean War.[4] Nightingale's work with nuns during that war significantly influenced her conception of nursing as a religious duty and as a disciplined and organized practice under a female hierarchy. She published *Notes on Nursing* in 1859 after returning to England from Crimea, and her celebrated status helped legitimize her vision of nursing.

By comparison, in the 17th century, St. Vincent DePaul and St. Louise de Marillac's Daughters of Charity were going out into the streets to do nursing. Then in 1841, long before Nightingale wrote her book, Mother Xavier Clark, superior of Elizabeth Seton's Sisters of Charity in the United States from 1839 to 1845, wrote "Instructions for the Care of the Sick" for sister nurses. She gave detailed instructions on prayer, but she also taught the sisters how to give medicines. They

were to keep them covered to prevent evaporation, avoid mixing them, know the correct doses, and use clean utensils and clean water in all the preparations.[5] *We still teach students these very techniques*. Nightingale wrote about lady managers, but before that, Mother Xavier taught that the sisters would be in charge. The experienced sisters should "know everything," so that they could guide the less experienced sisters and also teach the men who were caring for male patients.[6] While the sister's model emphasized self-abnegation, respect, and devotion, the nurse also was to seek knowledge and ask questions.[7] Those of us who study Catholic sisters acknowledge Nightingale as legitimizing nursing as a respectable field for middle class women, but the sisters' nursing became the model for the modern nurse, long before Nightingale came on the scene.

The care of patients at the time of death was particularly significant to sisters for its sacramental potential. Notwithstanding prevailing attitudes that a good death was one that occurred at home, nineteenth-century Catholic writers asserted that a Catholic hospital was the best place for Catholics to die. Patients could receive not only physical care based on modern technology but also the sacraments that the church sanctioned, and nuns would be present to see that important deathbed rituals were carried out. Catholic hospitals were places where the dying could make peace with God and organize their spiritual affairs before leaving

earthly life. Sister-nurses' notations confirm that they hoped to restore patients to physical health but also to help them with a "good death."

A stark contrast can be seen here between hospitals where the body of a deceased working class patient died with dignity in a Catholic hospital -- and the public hospital where the body was conceived as a source of cadavers for dissection. Rather than experiencing the fear and apprehension accompanying expectations of dying in a public facility, lay Catholics could trust sisters to dispose of the corpse in a respectful way.[8]

The Civil War was a defining event for the Catholic sisterhoods, when 600 sisters from 21 different communities nursed in military hospitals, US Navy hospital ships, tents, and improvised hospitals. While most women in both the North and South were not formally trained as nurses, (again, they cared for families at home) there were some women who *were* trained – not in the understanding of nursing today – but nevertheless, trained in some aspects of nursing. Not all religious sisters had nursing experience at the time of the Civil war, but the Daughters of Charity of St. Vincent de Paul did. (As I noted earlier, they had Mother Xavier Clark's "Instructions in the Care of the sick").These women turned their discipline, experience, and skill to the job at hand and arrived as ready-made nurses and hospital managers.

On June 9, 1862, when Satterlee Hospital in Philadelphia first opened, 25 Daughters of Charity reported for duty. Sisters did not volunteer individually for nursing service; instead, authorities such as medical and army officers or priest superiors specifically requested them. The Daughters of Charity had been requisitioned by Surgeon General William Hammond on May 25, 1862. On July 16 of that year, Hammond wrote to President Abraham Lincoln:

> We found in the Sisters of Charity, a corps of faithful, devoted and trained nurses ready to administer to the sick & wounded. No such organization exists among the Protestants of this country.[9]

Chaplain Nathaniel West at Satterlee also wrote about them: "There is probably not a hospital in the public service that would not be glad to have them."[10]

At a time when people still died at home, the four years of the Civil War overturned any expectations the soldiers had as they died in the company of strangers. It was nurses' roles to help them when they were dying, to comfort them, give them relics and crucifixes if they were Catholic, and write their families back home that they had, indeed, died well.

When the Civil War began, government oversight as we know it today was largely non-existent, but sisters did work with the government in ways that became innovative models of Church and State working together. For example, in 1864, the Sisters of St. Joseph in Wheeling, West Virginia, contracted with the Union

government for $600 a year for the sister nurses to care for soldiers at their hospital. The superior, Mother de Chantal Keating, was a young Irish immigrant who had come to America during the Irish famine years, and she strongly emphasized economic security. On Feb. 8, 1865, she personally appealed to authorities at the War Department in Washington, DC, when the army was delinquent in paying rent to the sisters. She presented her accounts and certificates and did not leave for two weeks until the quartermaster informed her that all arrears would be paid. In the 1890s Mother de Chantal and other sister nurses received US Army pensions for their work.[11]

And in 1924, a beautiful monument, "The Nuns of the Battlefield," was erected in Washington, DC, in their honor.

Then - during the Spanish American War, government and military officials once again asked sisters to serve, and 282 responded. For both the Civil War and the Spanish American War, nuns received government payments, and the government provided special grave markers for them. So - wartime was an important time for sisters to demonstrate their skilled nursing care, and their work helped enhance the general public's perceptions of Catholics.

By the late 19th century, hospitals across the United States were expanding. After 1890, doctors' powers of diagnosis were enhanced through the use of medical tools such as the stethoscope, x rays, and laboratory science. Hospitals

grew immensely, and thanks to the understanding of the germ theory, doctors could safely do surgery, which required a modern hospital to do so.

In this environment, sisters were, once again, innovative and also disruptive, because they were among the first to adopt an economically-based hospital model that was established upon finding and servicing markets of consumers. They went where Catholics and potential Catholics congregated and provided services for these specific groups. Over time, their hospitals transformed to modern medical facilities open to people from all religions and social classes.[12]

When sisters established their hospitals, they had to compete with multiple types of hospitals, each dedicated to caring for patients from certain social groups. Privately-supported voluntary hospitals were products of Protestant patronage and stewardship for the poor, and they were managed by lay trustees and funded by public subscriptions and donations, not patient fees. Because of the status and influence those hospitals could give them, physicians treated patients without charge. Public or tax-supported municipal hospitals accepted charity patients, including the aged, orphaned, sick, or debilitated. By contrast, Catholic hospitals were private but they were not primarily started to provide wealthy benefactors a means of patronage. Their main purpose was to heal and comfort the infirm, the sick, and the dying, provide up to date care, and afford patients the opportunity for repentance and spiritual solace.[13]

In the process, the sisters became true entrepreneurs. To build their hospitals and compete in this growing hospital marketplace, they developed sound business models, did market analyses, and received training as executives, lab technicians and eventually pharmacists. They raised and borrowed money, set up their own hospital corporations, and established relationships with mining and railroad owners. They knew that a hospital could not exist without nurses, so they trained their own. Eventually they opened schools of nursing to lay nurses to support their growing hospitals.[14]

Ex of clientele - miners (kind of environment sisters entered in the West).

And they found ways to help patients afford care, such as providing early insurance programs. (This was long before 1929 when Blue Cross appeared at Baylor Hospital in Dallas, Texas. as a means to help local public-school teachers to afford care).

So, just as sisters were innovators in nursing, they also formed innovative models of hospitals. With a few exceptions, they had to charge patients from the very beginning because of a lack of Catholic donors. For the sisters, paying patients could help supplement the care of those who could not pay. It wasn't until the early 20th century that non-Catholic hospitals began charging patients. Thus, it was sisters who created hospitals much more like today's market-oriented

hospitals, where they could link charity and market activities for charitable reasons.[15]

The pragmatic sense of themselves as service providers made sisters keep statistics, boast about their positive outcomes, and highlight significant cures in their hospital brochures. They knew that, without these activities, their hospitals could not attract the best physicians, offer the best services, compete with other health systems, and raise money needed for operations.

In Texas, the Sisters of Charity of the Incarnate Word in Texas created some of the first hospitals in the state. Because they had long stood outside and away from male authority, sisters offered a different way to "see" disease. As they gave excellent care to the physical body, they also integrated prayer into their nursing work. As an example, in 1889 a patient at St. Joseph's Infirmary in Fort Worth, Texas, began hemorrhaging early one morning, prompting the Sisters of Charity of the Incarnate Word immediately to telephone the attending physicians. Unable to locate anyone, the nuns tried several remedies, but none stopped the bleeding. At last, they reached one doctor who ordered interventions they had already tried. They thought that death was inevitable. Eventually, the bleeding stopped, but not before they spent several anxious hours observing and praying for the patient. As this example shows, the sister-nurses performed emergency measures first, called the physician, and then tried other remedies. Equally important, while they waited

for the doctor, they prayed. They did not see any contradiction in healing as spiritual and as somatic, and they performed measures for both. Indeed, one sister wrote, "Our heels are praying very hard all day!"[16] Most important, nuns' very presence could be a sign to others of a dimension beyond the visible world of everyday experiences.

As well, to the sisters, God could be encountered through created, finite things. Like churches, hospitals could be sacred places. Even among the Mormons in Utah, sisters established a hospital.

But throughout this time, religious and secular tensions remained. Americans of all social classes were expecting more from physicians, and the public yielded them greater authority. By the early 20th century, physicians had succeeded in enforcing new national standards for medical training and hospital accreditation, and they had expanded the range of symptoms and conditions that required their medical expertise. But, Catholic sisters understood power differently, and 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. Although sisters' nursing fit in well with the developing role of woman as domestic caretaker, in their hospitals they also took on administrative jobs that men traditionally held.

As an example, on October 27, 1903, at Sister Administrator Lidwina Butler's expressed wish, members of Salt Lake City's 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."[17] The physicians reflected their circumscribed position, however, when they stated, "We might as well burn it."[18]

Sisters realized that doctors could not work without hospital privileges, but nor could the sisters have hospitals without doctors, who brought in the patients. Thus they partnered with Protestant, Catholic, and Jewish doctors. Mother Alfred Moes worked with the Protestant Mayo Brothers as she established St. Mary's Hospital in Rochester, MN.

And since the sisters first cared for patients in the Baltimore city hospital in 1823, they demonstrated that they could engage with the government without being controlled by it.

The Great Depression created emergencies that caused a flood of legislation that affected all members of society, including hospitals.[19] The poor economy and expanding demands for free care led different hospital associations and administrators to work together for health policy in the political arena. They became avid proponents of the value of private hospitals as equal partners with government institutions.

Resolutions asking for government aid were passed at the 1934 Catholic Hospital Association Convention, but money could be accepted only under one condition: "federal relief to hospitals [did] not mean federal control." Implicit in the Association's resolution was the fear that the government might challenge hospital leaders' authority by becoming more involved in management issues. Eventually, they secured a ruling to allow government employees to be admitted to private hospitals, with reimbursement from the federal government but without significant government regulation.[20]

But real success in health reform did not come until 1945, and by then, Father Alphonse Schwitalla, shown here, was the Catholic Hospital Association president (in the 1930s and 1940s). In this photo, Fr. Schwitalla had just left a meeting with President Harry Truman, and he took his full arsenal with him. You can see the Daughters of Charity and other student nurses in background. Truman a Southern Baptist. Can you imagine that encounter? Religious authority!).

In 1945, Father Schwitalla and representatives from the Protestant Hospital Association and the American Hospital Association - for the first time - sponsored a bill that they themselves helped develop, culminating in the Hill-Burton Act, which provided federal grants to states for the construction of hospitals and health centers. In return, hospitals agreed to provide a reasonable amount of free services to people unable to pay.[21] Significantly, the bill restricted the government's role to determining how funds would be distributed to states, which meant no strings attached, and the Hill-Burton Act was signed into law in August 1946. Unfortunately, the Hill-Burton Act maintained "separate but equal" hospitals. It did not demand desegregation of hospitals as a prerequisite for getting federal dollars.

After World War 2, Catholic leaders did not yet embrace the view that everyone had a basic human right to health care, even through the government if necessary. It was not until 1965 during Lyndon Johnson's presidency, with a large Democratic majority in Congress, that Medicare and Medicaid were established to provide federal money for the care of the aged and the poor. And desegregation had to occur to get that money.

Here I need to say something about the country's horrible wounds of racism. Sisters did not always make the right decisions about admitting Black patients to their facilities. In the 1940s through the 1970s, however, the Sisters of St. Joseph

of Rochester, NY, established and ran Good Samaritan Hospital in Selma, AL, for Blacks. Here they became models of disruption. Not only did they open a hospital, but they also established a School of Nursing for Blacks, most of whom were non-Catholic. When the city made Blacks stand in separate lines at stores, the sisters stood in lines with the Blacks. They boycotted grocery stores that catered only to whites. Here you see them meeting Dr. Martin Luther King at Good Samaritan Hospital. In 1965, they did not march in with him from Selma to Montgomery, but rather took care of the marchers, such as John Lewis, when troopers beat the demonstrators to a pulp on what has become known as Bloody Sunday. In Selma, the sisters particularly understood what being a Catholic sister in health care meant by leading a life of struggle.[22]

It was also at this time that, as one sister noted, "Sisters in habits were replaced by men in suits."[23] After the 1970s, a major challenge for Catholic hospitals was that, for the most part, sisters were not the face of the hospital anymore as governance structures moved from the religious community to lay administration and trusteeship. In some hospitals, the bottom line pushed charity and compassion aside, with some sisters getting out of the hospital business altogether. Others began to establish health systems that met a variety of needs.

The secularizing tendency was enhanced by the greater bureaucratization of health care systems. Payments from Medicare and Medicaid, increasing insurance

payments, and more sophisticated fund-raising activities by independent organizations made the hospital less dependent on the religious orders for financial support. Governmental regulations, advances in science and technology, and market competition required all hospitals and health care systems, both secular and religious, to bow to the relentless call for cost containment. The sisters' free labor in earlier decades had postponed cost-containment concerns. But not anymore.[24]

To illustrate the unstable state of American hospitals at that time, a Providence Hospital chronicler in Seattle, Washington, wrote:

The "economic scene was precarious," the political scene "hyperactive," and "the religious scene fraught with confusion and anxiety."

In 1970, Sister Mary Maurita Sengelaub, a Sister of Mercy and a nurse with a master's degree in hospital administration, became president and CEO of the Catholic Hospital Association, the first sister to hold this role. She began working with Senator Edward Kennedy on health reform at an important time.

After Medicare and Medicaid provided increased funding, the for-profit hospitals had moved into the marketplace. But starting in the 1970s and continuing to today, hospitals decreased in number reflecting the era of hospital mergers. As well, patients were coming in for treatment but not staying, and out-patient facilities increased. Ambulatory surgery centers also grew, and more nursing homes were built, including those by Catholic sisters.

And significantly, as the federal government increased its funding for health care to more people, duplication of services grew as more and more facilities wanted access to those federal funds. Policymakers had to figure out how to avoid excess spending, and wage and price controls on hospitals started in 1971.

Also, Hill-Burton funds for hospital construction, which had started after WW2, came under fire from the Nixon administration. This program was folded into the National Health Planning and Resources Development Act of 1975, and federal hospital construction funds decreased. This 1975 Act included the development of national health policies with state and local area health planning committees. The Dept of Health, Education, and Welfare got involved, which implemented the law. This is also when we are seeing HMOs come about, to help with access to care, but they, too, became a business investment.

So how did Catholic hospital leaders react to all of this? In 1981, signifying a distinct change in policy, the United States Conference of Catholic Bishops called for an adequately funded national health insurance program. They emphasized the dignity of each human being and that health was a basic human right. And if it was a right, then the government had a greater responsibility to guarantee services. Respect for human dignity implied respect for the poor and universal access.

By 1992, the country had engaged in a major discussion about whether and how to reform the health care system. The following year, Catholic health leaders, led by Sister Bernice Coreil, influenced President Bill Clinton's health reform plan, one that favored the current employer-based health care system along with cost efficiency and universal coverage.

President Clinton purposely had Sister Bernice by his side on the White House lawn when he made a public appeal for the plan. He quoted her as saying that "health care is about basic human values, about honoring the intrinsic value of every person." But, as we know, it did not pass.[25]

Contextualizing the 1990s further, hybrid organizational forms had developed from the merging of Catholic and non-Catholic institutions, which challenged the identity of Catholic hospitals and drew the attention of the Vatican. And bioethical issues concerning abortion and reproductive issues, which countered Church values, were becoming matters of public policy. It was in this increasingly secularized environment that the Catholic hierarchy stepped up its influence on hospitals and health policy. Indeed, for the Church to be most influential in health policy, hospital leaders had to demonstrate not only an adaptation to the secular hospital market but also support of the Church's tradition of social justice. This gave them a powerful moral platform.[26]

The health care reform debates of 2009 and 2010, show how religious issues, power conflicts, and competing market interests still permeated the health care system. On March 17, 59,000 sisters joined Sister Carol Keehan and the Catholic Health Association to support President Obama's health care legislation. Asserting that it would "make historic new investments in support of pregnant women," the sisters declared: "This is the REAL pro-life stance, and we as Catholics are all for it."[27]

That sisters would take such a stand is not surprising. Again, they offered a different way of seeing the poor and oppressed. They experienced first-hand the problems that developed when poor women could not get prenatal care, and the tragic misfortunes that often resulted when the sick were left alone to care for themselves. The sisters' actions gave a degree of inspiration and political cover to some congressional members who then came out in support of the bill. On March 23, 2,010, President Obama signed the Patient Protection and Affordable Care Act.[28]

Their actions did not go uncontested, by the laity and by priests.

What I am suggesting is that such tensions have existed in American health care circles for well over a century. Throughout this time, sisters have a history of going out, relocating from the centers to what some historians call "the margins," of working with people who often were different from them. Today, they have

been joined by clerical and lay leaders, who also have shown visionary leadership. Members in this room are part of the vibrant lay leadership of Catholic health care systems today.

Other Catholic hospitals have not been so successful, and at times, sisters and other Catholic leaders have had to make painful decisions to close. In 2010, for example, St. Vincent's Hospital in Greenwich Village closed because it was millions of dollars in debt. Since its opening in 1849, it had been a beacon in the Village that had treated victims of disasters from the sinking of the Titanic to the Sept. 11 disaster. This also meant closing its outpatient H.I.V. program, which was the largest in the state. What St. Vincent's did NOT do to stay afloat was to sue thousands of patients and seize their wages and home equity in order to collect on overdue bills. Recall that during the Civil War, Mother de Chantal Keating in Wheeling *held the government* to its contract to pay her and her sisters in order the pay the bills, but it was NOT at the patients' expense.

In conclusion, we need the stories of Catholic sisters in health care, because they offer us hope for the future. Their history is not only one of successful ventures but also stories of floundering and sometimes failure. Their stories show that historically, tensions have erupted among the clergy, sisters, the government, and lay public that persist to the present. But sisters' successes in finding common ground and building coalitions among disparate entities have provided valuable

working models for how to blend the sacred and the secular. Their models are important parts of any strategic policy for improving health care for the world's citizens.

And I want to add another word about nurses. As I have argued throughout this talk, the vast majority of the sisters were nurses who started their hospitals. I ask you now to look around you, to your right and to your left, and if you don't see a nurse, then you are missing a great opportunity for solving today's problems with health care.

I will close with a quotation from Eileen Markey, who gave the keynote at the History of Women Religious conference last summer at Saint Mary's College in South Bend, Indiana. I believe this helps summarize the sisters as innovators and disrupters. She reminded us (quote) that when we do research on sisters, we tell "stories of God at work in God's church, imperfect…. but still holy. Transfiguration does not come in safety."[29]

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[1] Peggy Noonan, "Elijah Cummings and the Little Sisters," *Wall Street Journal*, October 26-27, 2019, A-13. https://peggynoonan.com/elijah-cummings-and-the-little-sisters/ Accessed December 17, 2019.

[2] Sioban Nelson, *Say Little, Do Much: Nurses, Nuns, and Hospitals in the Nineteenth Century* (Philadelphia: University of Pennsylvania Press, 2001).

[3] Barbra Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865-1925* (Columbus, Ohio: Ohio State University Press, 2005).

[4] In 1836, a German minister and his wife started the Institution of Protestant Deaconesses at Kaiserswerth, Germany. Nightingale completed a three-month training program there before studying in Paris with the Sisters of Charity of St. Vincent de Paul.

[5] Clark, "Instructions on the Care of the Sick," 4th, 5th, 6th, 8th. Archives of the Daughters of Charity of St. Vincent de Paul, Emmitsburg, MD.

[6] Clark, "Instructions," 13th.

[7] Clark, "Instructions," 5th.

[8] Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (Princeton, New Jersey: Princeton University Press, 2002); Ruth Richardson, *Death, Dissection and the Destitute* (London: Penguin, 1989).

[9] William A. Hammond to Abraham Lincoln, Wednesday, July 16, 1862. The Abraham Lincoln Letters at the Library of Congress, Series 1. General Correspondence. 1833-1916. See http://www.emmitsburg.net/history/article_index/war.htm. Accessed February 25, 2016.

[10] Nathaniel West, *History*, p. 27.

[11] Sisters of St. Joseph Archives, Wheeling, WV.

[12] Wall, *Unlikely Entrepreneurs.*

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid, p. 129.

[17] "Minutes of the Meeting of the Staff, Holy Cross Hospital," 12 November 1903, ACCN #588, Box 5, University of Utah Library, Salt Lake City, UT.

[18] "Minutes of the Meeting of the Staff," 17 December 1903, University of Utah Library. Sister Lidwina Butler was Superior at Holy Cross Hospital for eighteen years, from 1895 to 1913. See "Record of Apostolic Service, Sister M. Lidwina Butler," Archives of the Congregation of the Sisters of the Holy Cross, Saint Mary's, Notre Dame, IN.

[19] Alphonse Schwitalla, "Last Year's and Next Year's Work," *Hospital Progress, 12* (June 1931): 236-237; and Robert J. Shanahan, *The History of the Catholic Hospital Association, 1915-1965: Fifty Years of Progress* (St. Louis, MO: The Catholic Hospital Association, 1965).

[20] "U.S. Aid in Care of Indigents Asked by Catholic Group," *Hospital Management* 38, no. 1 (July 1934): 34-35, 43. Quotation is on p. 34. See also Shanahan, *The History of the Catholic Hospital Association*, 119, 121.

[21] Alphonse Schwitalla, "19th Resolution, 1942 CHA Convention," *Hospital Progress, XXIII* (October 1942): 306-307; and ibid., "The Hospital Construction Act," *Hospital Progress, XXVI* (January 1945): 27-31.

[22] Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions* (New Brunswick, NJ: Rutgers University Press, 2011), chapter 4.

[23] Ibid, p. 1.

[24] Ibid.

[25] Ibid, p. 123.

[26] Ibid, p. 123, 125.

[27] Ibid, p. 184.

[28] Ibid.

[29] Eileen Markey, "Finding What's True in the Stories of Women Religious," *American Catholic Studies Newsletter* (Notre Dame, IN: Cushwa Center, Fall 2019): p. 9.