Fulfilling the Sisters' Promise

The Heritage of Healthcare's Early Days

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Summary Members of religious orders—the sisters—built not just Catholic healthcare, but healthcare in America. A good 50 years before Henry and Edgar Kaiser got the idea, prepaid capitated health insurance was being offered by sisters who looked at what was needed and realized this was simply the best way to get it done.

The sisters also created the integrated healthcare system at a time when the emerging medical elite wanted nothing to do with any patient who was not socially acceptable and potentially curable. They arranged a continuum of care for the aging sisters within their own communities. And they understood the concept of social medicine, of population-based healthcare, of healthy communities, long before these ideas became commonplace.

But the sisters are gone, most of them. The question today is, How do we preserve the sisters' heritage and transfer it to a new millennium, a new healthcare system, and a new set of rules?

First, it is important to understand that much of what we remember the sisters for—courage, compassion, vision—was not unique. They created many of the structures that today are the new models; but they were not alone. However, three aspects of how they expressed their vision and their faith were unique to the sisters and must be understood by those who wish to tread the path the sisters blazed:

- The purity of their commitment and its underlying philosophy—that the helpless and the sick must always be the point of the exercise—should pervade Catholic healthcare to its soul.
- These women, living in poverty, represented, and still represent, a singular group: a group of women who, having told the world that their only wish is to serve others, humbly, became CEOs of vast systems and trustees of huge enterprises, without ever abandoning that simple, original pledge.
- Although they bowed to the rule of obedience, and they were humble, *they were fighters.* They spoke out against poverty, bigotry, the shunning of those with certain diseases, lack of access to healthcare, stupidity, ignorance, and hate.

In examining the history of healthcare, historians generally accept that members of religious orders—the sisters—built much of what became the Catholic healthcare ministry. However, I think we have sold the sisters short. Those prodigious women who came here—first from Ireland, Germany, and Switzerland, and later from Canada—built not just Catholic healthcare, but healthcare in America.[1]

Today, as we listen to consultants, economists, politicians, and academics congratulating themselves and each other for designing the emerging configurations of care, we might be persuaded that capitation, integration, and managed care fell off the turnip truck at some health economics conference a few years ago.

The Roots of Capitation

But these ideas are hardly new. Take, for example, Sr. Amata Mackett, a six-foot-tall Duluth Benedictine, who in the 1890s, in full-length habit, trudged from lumber camp to lumber camp in wild northern Minnesota, selling the timber workers tickets for $1 to $5, good for a year's worth of care from the Benedictines. The employers liked the idea so much that they started deducting the amount from the lumberjacks' earnings. This arrangement was also probably preferable for the lumberjacks, more than a few

In the 1890s the Benedictine sisters in northern Minnesota sold timber workers tickets for $1 to $5, good for a year's worth of care. This little HMO was so successful that the last ticket was redeemed in 1936. (All photos from Suzy Farren, *A Call to Care*, Catholic Health Association, St. Louis, 1996.)

of whom were chased by Sr. Amata with a fire poker for failing to pay up. The Benedictines' little HMO was so successful that the last ticket was redeemed in 1936.

Mother Joseph of the Sisters of Providence in the Northwest also started something like an HMO for timber workers in Washington and Oregon. The Sisters of Saint Joseph in Pittsburgh, KS, were paid $80 and 15 tons of coal each month to care for miners employed by the Santa Fe companies. Later the miners paid 25 cents a month for care. The Sisters of Charity of the Incarnate Word in Fort Worth, TX, were paid by the railroad to take care of its employees. The Sisters of Saint Joseph of Peace in Bellevue, WA, were paid $10 per lumber worker; the Franciscans in Little Falls, MN, received $7.

This was what we health policy types call "prepaid capitated health insurance." It did not spring from the mind of a tenured academic somewhere; it came from the sisters, who looked at what was needed and realized that this was simply the best way to get it done. They created capitated care a good 50 years before Henry and Edgar Kaiser got the idea.

Pioneering Integrated Systems

The sisters also created the integrated healthcare system; they just did not know it. To them, healthcare was healthcare; if patients were chronically ill, or were mentally ill, or had acute conditions, or were old and frail, it was all the same to them.

This was in striking contrast to the secular healthcare system that arose when the first great private hospitals were built in New York City, Philadelphia, and Boston. These secular institutions had very specific clinical and social priorities: Of the sick poor, only those who were deemed "deserving" and who had acute illnesses were admitted. The mentally ill, the chronically ill, orphans (as if, somehow, their situation were their own fault), unwed mothers (even those who had been raped by their employers), people of color, and immigrants without family went to the hard comfort of the almshouse. The emerging medical elite wanted nothing to do with any patient who was not both socially acceptable and potentially curable.

Meanwhile, the sisters founded orphanages, schools, nursing homes, and shelters for the aged, for cast-off elderly slaves, for unwed mothers, for orphans, and for many others. And they arranged a continuum of care for the aging sisters within their own communities, so the elderly sisters could receive acute care, long-term care, shelter care, housing, congregate living, and, in the end, hospice.

But the early sisters never combined capitated payment, a spectrum of different levels of care, and integration of all services into one system. That has only happened recently.

A Broad Vision of Health

In addition to capitation, integration of services, and a continuum of care, a fourth healthcare concept pioneered by the sisters is that they did not make distinctions between what was clinical and what was social. They provided nursing care, to be sure; but they also read to the illiterate while they were dying, sang to those who were lonely while they bandaged their wounds, and taught children their letters while they cleansed sores caused by Hansen's disease. They understood the concept of social medicine, of population-based healthcare, of healthy communities, long before

The last unique legacy of the sisters, lost in recent years, is simply this: Although they wore habits (some still do), and they bowed to the rule of obedience, and they were humble, *they were fighters*. They were Sr. Providencia in Spokane in the 1950s, criticized from within her own order for working with Native Americans.

these ideas became commonplace. Capitation has made social medicine financially attractive to providers today; but the sisters long ago understood the value of going beyond purely clinical activities. After all, they were already working under capitation; they understood that it was better to keep the tree from falling on the lumberjack than to do a clean amputation once it had fallen.

That is one reason that so many sisters viewed racism as just as much of an enemy as infection, and why they have consistently recognized poverty as the pathological agent it is. As we look today at the precise lines drawn between what is clinical and what is social, with confrontational camps lined up on either side of that line, ready to protect their turf at all costs, we might well wonder what Mother Cabrini would think.

We also might wonder what the sisters would think of the lives of children in the South Bronx, a stone's throw from the glittering palaces of Manhattan. In a park in which drug dealers ply their trade, teddy bears are tied to a tree to distract the addicts' children as their parents make their buys, and so many toxic waste incinerators have been installed that children must stop to use asthma inhalers every 200 feet.[2]

And one wonders what the sisters would think of what happened in Chicago in July 1995, when, on a very hot weekend, 733 people—almost all elderly, poor, and minority—died of hyperthermia in their homes or on the streets because no one was looking after them. Most of them had Medicaid, Medicare, or access to public health services. But they were confused, or old, or homebound, or addicted, or afraid to leave the house. And they died. Fat lot of good their coverage did for them!

Where was the case management? Where were the primary care providers? I have to believe that if they had been members of an integrated managed care plan, they would not have died.

I told that story at a managed care conference recently, and the medical director of a large for-profit plan came up afterward and said, "If you make social demands like that on managed care, it will fail." And I replied, "If it cannot fulfill such needs, then it *should* fail."

Those providers who wish to become involved in direct contracting and cut out middleman for-profit HMOs must realize that when they take on such contracts, they take on total responsibility and risk for each patient's health. If providers blow it, and their members are found dead of heat with their windows nailed shut, those providers will not see their contracts renewed, and there will not be any nasty for-profit health plan to blame.

The sisters of old would have done better, because they knew better. They knew that heat could kill; it killed some of them.

Preserving the Heritage

But the sisters are gone, most of them. The question today is, How should their legacy be carried on? How do we preserve the sisters' heritage and transfer it to a new millennium, a new healthcare system, and a new set of rules?

These are different times from when the sisters created so much of the system's infrastructure. They were poor; healthcare today is fat and sassy. They were not concerned with the market; today, the market is supposed to be the magic bullet that will solve all our ills. They were hardly in it for the money; today, healthcare is the entrepreneur's playground. The idea of healthcare for profit would have been absurd to them; today, the profiteers are gorging themselves at the trough.

How do we preserve the sisters' heritage and transfer it to a new millennium, a new healthcare system, and a new set of rules?

There are many good things about this new healthcare world: The models that the sisters created, the models that were largely forgotten for so long, are now finally coming into their own. And even if we have failed the uninsured thus far, the issue is with us, ever more strongly, and will soon be back on the political agenda because of the sheer force of numbers. The Census Bureau reports that 61 million people

were uninsured as of March 1995.[3]

Even the market, that brainless, heartless arbiter, has shaken healthcare folk hard enough for them to realize that there is not limitless money, that not everybody in healthcare is a good soul, and that it is time to stop letting petty squabbles and old arguments get in the way of what must be done.

But is there any relevance today, in such times, to the story of the Grey Nuns, who walked through the wilderness from Montreal to the Red River colonies of Manitoba to care for children, or of the sisters who climbed mountains and crossed canyons to create little healthcare outposts here and there? Can we learn anything from the sisters who fought smallpox, diphtheria, typhus, cholera, yellow fever, malaria, and war—and sometimes died of these plagues themselves? What have they left us that we can apply to our own situation? What was so special about their work that it should influence us today?

A Unique Legacy

First, it is important to understand that much of what we remember the sisters for was not unique. Courage, compassion, vision—all those characteristics that we rightly celebrate—were not their special province. Yes, the sisters created many of the structures that today are the new models; but they were not alone. There were early physicians such as Michael Shadid, the immigrant doctor who created the first capitated physician-hospital organization in this country in 1929, and who faced litigation, persecution, discrimination, and professional isolation.[4] Organized medicine even tried to get his physician sons drafted.

There were also the miners, lumber workers, labor leaders, farmers, fishermen, and others who created prepaid health care plans against all odds, and were condemned as communists and socialists.

Yes, the sisters founded fine institutions. So did the Deaconesses and Lutherans and Methodists. So did the Jews—often because their physicians were not allowed to join the medical staffs of existing facilities, including those of many Catholic hospitals. So did the immigrants, who, like the sisters, went out and begged and sold their possessions to achieve their dreams. So did the king and queen of Hawaii, who in the 1850s went door to door to raise money for what is today the Queen's Hospital in Honolulu.[5] So did African Americans, who founded a network of hospitals and nursing and medical schools, because there was no place for them at the table.

Nor was it simply that the sisters were of service, because many people—most people, at one time or another—are of service. Service in healthcare is neither unique to one group nor subject to one definition; it is a thread of our lives. It was part and parcel of what the sisters did; but it is part and parcel of what most of us do, at least sometimes.

No, if we seek to plumb the hearts and souls of those long-ago sisters because we wish to carry on what they believed in, then we must look elsewhere. Those who wish to tread the path the sisters blazed can do so by understanding how they expressed their vision and their faith. Three aspects of this expression *were* unique to the sisters.

A Purity of Commitment First, they did what they did for reason of neither blood ties nor money, but because they found genuine joy in taking care of strangers, especially strangers whom no one else wanted to bother with. This is true of many people in nursing and in medicine, but nurses and doctors get paid. It is true of many hospital and healthcare administrators, and of many others who work in healthcare, but they, too, get paid.

Mother Marianne, voluntarily exiled in Molokai with Father Damien in the 1880s to care for the lepers there, did not just tend to the girls' home. It is widely believed in Hawaii that Mother Marianne received Damien's confession and shared Eucharist with him. There, they speak of Damien and Mother Marianne as partners.

The fact that love could bloom, risks could be taken, and entire systems could be created from crumbs, when the object was to care for the scorned, the shunned, the forgotten, the human road kill of this society—with no personal income earned—is unique in the history of the United States.

Should Catholic healthcare folk, then, go back to poverty and begging? Like the sisters of St. Rose, should they turn their backs on even Medicaid and Medicare? Of course not. The point is that making money was never the objective of Catholic healthcare; it was always a means to an end. And sadly, in these latter days, Catholic healthcare, in too many cases, has wan-

dered away from money as a means and has instead fallen into the trap of money as an end.

The purity of the sisters' commitment was, and is, unique. And its underlying philosophy—that the helpless and the sick must always be the point of the exercise—should pervade Catholic healthcare to its soul, in every contract, in every continuing education session, in every business decision, in every hiring. I have never liked the supposedly funny line, "No margin, no mission." I prefer the corollary posed by Don Berwick, MD, of the Institute for Healthcare Improvement: "No mission, no margin."

Pride and Poverty The second unique aspect of the sisters' legacy is that these women, living in poverty, often in dire straits, at risk of every kind of horror, and often not highly educated, nevertheless represented, and still represent, a singular group even in this diverse society: a group of women who, having told the world that their only wish is to serve others, humbly, became heads of multi-million-dollar entities, CEOs of vast systems, and trustees of huge enterprises, without ever abandoning that simple, original pledge.

Nowhere—not in nursing, nor in teaching, nor in social work—have women who disdained money, vanity, and personal power ended up with so much money, prestige, and power. And few people of any kind have done so much good with it. Nursing philosopher Andrew Jameton, PhD, has said that in this country, to be of service is to be exploited[6]; that was not true of these women.

Sr. Antona, an African-American nun, in 1962 walked into the murderous hell of Selma, AL, her life essentially forfeit, and announced, "I am here because I am a Negro, a nun, and a Catholic, and I want to bear witness." Her fellow Sisters of Charity, all white, marched in New York City to support her.

The greatest challenge to Catholic healthcare is not the threat of for-profit hospitals and health plans; most of them will be gone in time, albeit after doing a lot of damage. Nor is it issues of reproductive health, as thorny as these may be. It is that there will be fewer sisters in the future, and therefore that spirit—that crystal-pure charitable spirit, that pride in eschewing material things, but, most important, that majestic insistence on serving—must somehow be kept in other vessels, in other ways.

The passing of so many sisters from the scene over the next decades will leave us with only a few members of the only group of people in this society who ever stood up and said, "I'm female. I'm poor. I desire to be of service. *And I expect to be, and demand to be, treated with the respect that is my due.*" And even this hard society, this flinty-eyed land, tipped its hat to them as they passed by. Somehow, lay Catholics of both sexes are going to have to carry that on.

A Fighting Spirit The last unique legacy of the sisters has been lost in recent years, lost in the face of the women's movement, growing secularization, and the monetarization of healthcare. It is simply this: Although they wore habits (some still do), and they bowed to the rule of obedience, and they were humble, *they were fighters.* They were not given to taking no for an answer. They fought the law, the mores of the time, their own superiors, the land, the weather, disease, war.

They were Sr. Providencia in Spokane in the 1950s, criticized from within her own order for working with Native Americans. They were the sisters in Wheeling, WV, who hired three African-American nurses in 1951 and, when most of the white nurses refused to work with them, rode out a three-month strike rather than fire the Black nurses.

They were Mother Marianne, voluntarily exiled in Molokai with Father Damien in the 1880s to care for the lepers there. She did not just tend to the girls' home. Damien, who had contracted Hansen's disease himself, had lived in spiritual isolation for years, and it is widely believed in Hawaii that Mother Marianne received Damien's confession and shared Eucharist with him. There, they speak of Damien and Mother Marianne as partners; they do not mention one without the other. And although it is not my place, I do hope that she will receive the same recognition from the Church as he is receiving, for he would not have been able to do his work without her.[7]

The story of the sisters' strength is also the tale of the Sisters of the Sorrowful Mother, who tried for 10 years to run a hospital in Wichita, KS, and who, saddled with debt, were told in 1899 to give it up and come home. They considered this order very carefully and proceeded to ignore it. St. Francis Regional Medical Center will turn 108 years old this year.

It is the story of the Franciscans who went south to Mississippi during the 1960s to work with poor Black folk, who were jailed and abused and maced, and who are still there. It was Sr. Jo B in the 1970s, told that she could not set foot on a private farm to inspect a migrant worker camp,

telling the owner, "I work for the government, and I can set foot on whatever property I want."[8]

It is Sr. Mary Rose McGeady of Covenant House, who, upon hearing Newt Gingrich's pronouncement in 1994 that poor children should be consigned to orphanages, called him up and challenged him—and eventually got an apology.

It is Sr. Antona, an African-American nun, who in 1962 walked into the murderous hell of Selma, AL, her life essentially forfeit, and announced, "I am here because I am a Negro, a nun, and a Catholic, and I want to bear witness."[9] Her fellow Sisters of Charity, all white, marched in New York City to support her.

The foes are always pain, suffering, abandonment, greed, heartlessness, and hatred.

These were no ladies' embroidery societies. These women were not and are not shrinking violets. They spoke out against poverty, bigotry, the shunning of those with certain diseases, lack of access to healthcare, stupidity, ignorance, and hate. They did so at the risk, and sometimes at the cost, of their lives—not because they held their lives so cheap, but because they held the lives of others so dear.

And so, if we want to carry on their work, we cannot think, or work, or talk in timid terms or tones. Their goal was clear to all. They shouted it, they screamed it, but even when they spoke it in measured tones, quietly, it rang like a bell: "We are going to do what needs to be done, and you can either join us or get out of the way."

Today, the sisters of old would be working with AIDS patients, with the rural poor, with the very young and the very old for whom this country so often has no use. They would be holding this country's feet to the fire about the fact that 61 million of us must beg for care, that policymakers seriously discuss tossing 9 or 10 million destitute children off Medicaid, that too many people believe that women and people of color and kids need no special protection because we are such a nice, color-blind, gender-neutral country now. They would be working in their communities, going where the need is, still teaching school and teaching healthy behaviors, binding wounds and soothing souls, fighting for what ought to be done and fighting against those who would rather avoid the truth, play for time, disappear into politics, and hate.

These are the things that they did, and that many in Catholic healthcare are still doing in following their example. As political analyst Mark Shields has said, "We have all warmed our hands at fires built by others."

And no matter how hard it is, you must keep it up. You must keep on shouting, keep on fighting, keep on doing things the hard way. Very few of the challenges facing us today hold a candle to what they had to do, *what they wished to do.*

And it was a candle—a light—that the sisters passed on. It is in your hands now, in a different sort of struggle, with what may seem like different adversaries, but they are not: The foes are always pain, suffering, abandonment, greed, heartlessness, and hatred. And I know that you will keep finding new ways to fight them, because that is what you want to do—not *have* to do, not *should* do, but *want* to do. Because there is little else in this life that is half as much fun as kicking the bad guys in the shin.

And, as you go to work with that candle in your pocket, in your hand, in your heart, if you hear a rustling in the wind, a murmur in the trees, a sort of tickle at the back of your neck, don't worry about it. It's just Mother Marianne, and Mother Joseph, Sr. Amata, Father Damien, Sr. Jo B, and all their company, saying, "You take that light we gave you, Brothers and Sisters, and you hold it high." □

NOTES

1. Suzy Farren, *A Call to Care*, Catholic Health Association, St. Louis, 1996; Emily Friedman, "Capitation, Integration, and Managed Care: Lessons from Early Experiments," *JAMA*, March 27, 1996, pp. 957-962. Some historical information presented here also came from the author's ongoing work on the history of healthcare in Minnesota and on the history of group practice and capitated arrangements.
2. Jonathan Kozol, *Amazing Grace*, Crown Publishers, New York City, 1995.
3. Robert Cunningham, "Shrinking Private System Maroons the Uninsured," *Medicine and Health Perspectives*, April 29, 1996, pp. 1-4.
4. Friedman, "Capitation, Integration, and Managed Care."
5. Emily Friedman, "*The Aloha Way: Health Care Structure and Finance in Hawaii*," Hawaii Medical Service Association Foundation, Honolulu, 1992.
6. Emily Friedman, "Nursing: Breaking the Bonds?" *JAMA*, December 26, 1990, pp. 3,117-3,121.
7. Gavan Daws, *Holy Man*, Harper & Row, New York City, 1973.
8. Farren.
9. Farren.