

Catholic Health System and Member Hospital History



Mission and Initial Founding:

Prior to the twentieth century, Catholics became involved in organized health care not so much to *cure* patients as to tend to their physical needs and to ready their souls for death (Starr 1982:145). In contrast, Protestant churches concentrated less on founding institutions for tending the sick than on morally “cleaning up” the bad habits of slum dwellers, which were thought to cause disease (Kauffman 1995).

As a result of this difference in theologies, organized health care in the early U.S. was performed primarily by Catholic religious orders, rather than by Protestant denominations. The sisters’ original reasons for engaging in this work were threefold:

- Tending a sick person was tending Christ. (Matthew 25 – “Whatsoever you did to the least of my brothers, you did to me.”)
- By tending and converting the sick before their death, the sisters were literally snatching their souls from the grip of the devil and delivering them to paradise (Nelson 2001:104-109; McNamara 1996:624, 627).
- Many Catholic immigrants wished to safeguard their own culture, language, and religion, and preferred to be nursed by sisters from their home countries when they were ill (Dolan 1998:197; McNamara 1996:624).

The religious order studied for this project expressed a similar ideology. The original rule of their founder and its 1812 adaptation for the United States both stated that one of the chief employments of the sisters was to assist the sick poor, “recollecting that it is not so much upon them as upon Jesus Christ that they bestow their services.” The sisters were also admonished “every now and then to suggest to [the patients] pious thoughts in order to dispose them to patience, or to make a good general confession, or to die well. They shall be very careful to instruct them in the things necessary for their salvation and to procure them in good time all the sacraments.”

By the late nineteenth century, however, medicine had advanced to the point that hospitals were actually able to cure some patients. Catholic hospitals soon began to add a new theological reason for their existence: to restore patients to health in imitation of Christ, the Divine Physician. Still, as late as the 1950s, Catholic hospitals prided themselves on being places where spiritual as well as physical needs were addressed, and where “virtue works wonders which technical aids and medical skills alone are powerless to accomplish.” (Risse 1999:468) This spiritual atmosphere was primarily generated by the presence of the sisters.

As hospitals grew and were more and more bound by government rules and professional Standards, it became necessary to articulate a new theology or *raison d’etre* for why Catholics should be involved in them. One 1997 publication argued that what was most important for the health care provided by the sisters is the *integrated service*.

Everything is patient-centered. The efforts of everyone involved, administrators, chaplains, medical personnel, and support staff, are directed toward *quality* care for the patient in an atmosphere that reflects the foundational quality of hospitals at their origin, namely “*hospitality*.” The publication listed the following as Essential Attributes of the sisters’ health care:

1. Spiritually rooted
2. Holistic
3. Integrated
4. Excellent
5. Collaborative
6. Flexible
7. Creative
8. Focused with a preferential option for the poor as central to its mission.

(Sullivan 1997:49)

Still, however, it was hard to see what specifically would distinguish this list from a similar list compiled by a hospital in another faith tradition, let alone by another religious order within Catholicism. Critics complained that Catholic hospitals were more focused on making money than on caring for the poor, and that they really did not devote a larger proportion of their annual budget to charity than public, private, or for-profit hospitals did (Langley 1997).

By the 1980s, economic constraints made it difficult, and soon impossible, for a hospital to operate as a stand-alone facility. In 1986, the sisters established a hospital system to encompass all 38 of their facilities; in 1999, this hospital system merged with another system run by a different order, thus creating what is now the largest Catholic health system in the United States. Those in charge of safeguarding the Catholic mission in health care in the system's member hospitals have devised a series of formation programs for hospital personnel from the level of chief executive officer to director. It includes these specific courses/programs:

- *Leadership Formation Program* ~ a 2 year certificate program for 25 intentionally selected leaders each year. About 150 persons have completed this program or are currently enrolled.
- *Ongoing Executive Formation Program* ~ all Mission VPs at each local health ministry are trained to provide this course (consisting of 6 detailed modules) to the local executive leadership team. Several hundred executives of system hospitals have completed this program.
- *Physician Formation Program* ~ includes the Ethical and Religious Directives for Catholic health organizations.
- *Spirituality in the Workplace* ~ each Mission VP is responsible to do goal-setting and annual reporting on goals/objectives relative to integration of spirituality at their respective ministries
- *Care of those who are Poor and Community Benefit* ~ each local health ministry, under the direction of the Mission VP and Finance leader, is responsible to fulfill specific goals related to this important component of Catholic Social Teaching, e.g., health care access for uninsured/underinsured; just wages; respect for life at all stages, etc

Milestones:

- 1633 The foundation date of the religious order. The following year, the sisters began visiting the sick at the Hotel-Dieu of Paris. During the next twenty years, the sisters were established in hospitals and houses of charity for the service of the sick poor throughout France.
- 1789 The sisters ran 426 hospitals in France, Poland, Austria, and Silesia.

- 1808 A new religious order was founded in the United States, adapting the Rule of French sisters. This U.S. order later affiliated with the French one.
- 1823 The first invitation to the sisters in the United States to undertake the care of the sick was received. They thus became the first religious sisters in charge of a hospital in the United States. Over the next thirty years, the sisters staffed several other public hospitals and infirmaries in the country, especially during the cholera epidemic of 1832, the smallpox epidemic of 1836, and the typhus epidemic of 1847.
- 1862 The hospital in the current study was opened on land donated by a wealthy local Woman and was the first Catholic hospital in the city. The first board consisted of sisters and a small number of sisters did all the nursing, administrative, housekeeping, and fundraising tasks at the hospital. The announcement of the hospital's opening stressed that all persons would be admitted without regard to religious affiliation.
- 1863 The hospital moved to property purchased and donated by a wealthy local man, who asked that it be renamed in honor of his wife. This was done in 1863.
- 1875-6 The hospital moved to its present location. Money for the new hospital was borrowed at 6% interest: \$50,000 on July 27, 1875 and \$30,000 on April 12, 1876. Proceeds from the sale of the original building were also used.
- 1895 Establishment of the hospital's School of Nursing. The first five students were from a local orphanage. They graduated in 1896.
- 1907 The hospital's Ladies Auxiliary formed.
- 1915 The Catholic Hospital Association was founded to assist Catholic hospitals in keeping pace with modern institutions and to meet the newly-developing national standards. While sisters were not permitted by Church law to occupy the top executive positions of the CHA, they comprised the vast majority of the members and were active on the CHA board and committees.
- 1949 The hospital in the present study is approved for the Training of Interns and Residents in Surgery, Medicine, Obstetrics & Gynecology by the A.M.A. American College of Surgeons; American College of Hospital Administrators and Catholic Hospital Association as well as the State Examining Board. The school of nursing was also accredited by the State Board of Nurse Examiners.
- 1949 The hospital started to pay Social Security for lay employees. In this year, the hospital employed 26 sisters; one resident chaplain; 12 house doctors; 86 student nurses; 56 graduate nurse staff; 77 lay men employees; 232 lay women employees.
- 1954 Full accreditation by Joint Commission on Hospital Accreditation.

- 1961 Dedication of new hospital building.
Statistics: 700 employees, including 20-25 sisters
- 1969 First collaboration between the sisters' hospitals for shared services in the southeastern United States.
- 1977 Creation of a foundation to co-ordinate fundraising for the Hospital.
- 1982 Expansion of collaboration between the sisters' hospitals nationwide: incorporation of a National Purchasing Service.
- 1986 Establishment of the sisters' National Health System. This included 38 hospitals in 17 states, with 33,000 employees.
- 1996 The first lay (male) CEO of the sisters' National Health System appointed.
- 1999 A merged health system is created, including the sisters' National Health System, plus the health system of another order. This included 67 facilities.
- 2002 Three provinces of a third order join the merged health system.
- 2006 The first two lay members are added to the merged health system's Sponsors' Council.
- 2008 The local hospital in the present study initiates a \$212 million renovation and expansion plan including improved infrastructure, expansion of the Cancer Center and a new patient tower.
- 2007 The merged health system moves toward a policy of "Sponsorship of the Whole," centralizing the disbursement of monies in its central offices. Previously, financial and policy decisions had been made locally.

Agency Financial History:

Nineteenth and early Twentieth Century: As was the case with all Catholic hospitals of the time, financial support of the hospital in the nineteenth century was primarily through gifts from charitable donors. Since it was located in a predominantly Catholic city, the donors appear more likely to have been Catholic than may have been the case in other parts of the country. Sometimes these donations were given to the local bishop, who then gave them to the sisters. Examples of these donations include:

Land Donations

- 1861 – 30 acres of land
- 1862 – five acres and a house worth \$10,000.

1874 – more property given to the bishop, who gave it to the sisters for the relocation of the hospital.

1891 – a sugar plantation in Louisiana; revenue from the rent (1891-98) and sale (1898) to be used by the hospital

Paying for the Construction of Buildings

1862 – one donor paid for the construction of the first 2 wings of the first hospital

1890 – another donor financed the building of a new wing

1910 – a family gave \$2,000 for a new children's wing

1927 – a member of the same family financed a building for chronic and incurable patients

Monetary Donations

1865 - \$200 gold

1890 – \$100,000 to support the staffing of the new wing

1911 – \$53,000 to start a trust fund yielding \$2,200 interest/year

1916 – \$1,000 donated by the local bishop

\$10,000 to the trust fund, by the donor who started the fund in 1911

1922 – \$5,000 worth of bonds

Volunteer and In-Kind Services

1860s- A family provided furnishings for the sisters.

Various Catholic schools donated small items when the hospital first opened.

In the mid-nineteenth century, the doctors serving at the hospital did so for free

1938 – A service organization of young women was founded to provide volunteer services.

A lesser amount came from fees paid by patients: \$1.50-\$2.00 per day for patients in the general ward; \$5-\$10 per day for a private room.

The sisters also periodically borrowed money from local banks, later paid off through donations, the sale of donated property, or fund drives.

Beginning in the early 1900s, mention begins to be made in the board minutes of income from stocks and bonds.

Mid- to Late-Twentieth Century: While there is mention in the archives as early as 1871 of some monies (\$500) being received by the hospital from the state legislature, governmental funds did not form a large part of hospital revenue until the initiation of Medicare in the late 1960s. Other new sources of funding included insurance payments from Blue Cross/Blue Shield and other similar companies beginning in the 1940s. And, of course, the doctors were no longer volunteering their services: board minutes from the mid-1950s mention that the Chief of Pediatrics was paid \$20,000, with other staff physicians receiving raises of \$100 per month.

The relative proportions of the hospital's funding from patient fees as compared to charitable donations was by this time reversed: whereas in the 19th century the hospital had received the bulk of its income from donations and a lesser proportion from patient care, the ratio was now the opposite. Selected figures from the annual reports make this clear:

- In 1971, the hospital received \$17,669,815 (whether from Medicare/Medicaid or from private insurers) for delivering patient services, and only \$285,841 from "other" sources such as gifts and interest on investments.
- In 1981, the hospital received \$52,133,414 for patient services and \$516,845 from "other" sources.
- In 1991, the hospital received \$138,997,000 for patient services and \$1,316,000 from "other" sources.
- In 2003, the hospital received \$226,182,000 for patient services and \$3,724,000 from "other" sources.

The percentage of revenue from gifts and investments, therefore, has averaged between 1% and 2% of total revenues from the past 35 years. This includes the funds raised by the hospital's Foundation for Special Projects.

Official Church sources rarely donated monies to the sisters' hospitals directly, although the hospital's archives mention several times in the 19th century when the local Bishop channeled donations that had been given to him by wealthy Catholics on to the hospital. The sisters rarely contributed money to the hospital, although the donated or subsidized labor of the 19th century

sisters accounted for a large in-kind contribution. By the mid-20th century, however, when most of the hospital's revenues began to come from insurance and government sources, the sisters realized that any savings resulting from their reduced stipend would benefit the insurance companies, not the patients they served. From that time on, therefore, the nursing sisters were paid salaries equivalent to those of their lay counterparts (Risse 1999:541). In many religious orders, these "full salaries" of the sisters in nursing and hospital administration were essential for the financial solvency of their orders, since teaching sisters' stipends were still averaging only a few hundred dollars a year as late as the 1960s.

With the creation of the merged health system in 1999, the financial relationship between the sisters and their hospitals changed again. Now, each hospital pays a "sponsorship fee" to the health system. The sisters receive a percentage of this fee, which helps to support their own expenses. In return for this fee, the hospitals receive access to the system's services and its national reputation. Also, the sisters are free to contribute their services to a sponsored hospital wherever they discern a need. A hospital department usually welcomes a sister's services since she is "free" to that department's budget line. Still, since there aren't enough sisters to go around, some hospitals paying the system's sponsorship fee have no sisters serving on their premises.

This system has caused some tensions which are still being resolved. Until recently, each component region of the system had collected the sponsorship fee separately and distributed it to the hospitals within that region. The system is now moving to a "sponsorship of the whole" model wherein all sponsorship fees will be sent to the main system office and redistributed across regions. As one of the founding members of the system noted, "There can be difficulties when a member hospital or region sees its own needs more than it sees the needs of other regions or the whole."

Changes in the Sponsor-Hospital Relationship:

In France during most of the time since the 17th centuries, the state owned the hospitals, and the sisters were responsible for running them. The sisters admitted the patients, provided staffing, kept accounts, and administered the hospitals. The state, in return, paid the order a fixed sum per year.

Initially, the United States followed the same arrangement. However, it soon became more common for the sisters to own their own hospitals. The hospital was separately incorporated in 1862. There were no diocesan representatives (bishop or clergy) on the hospital's board of directors. In fact, there were no outside representatives at all; the board chair was the sister who was the hospital administrator, and the remainder of the board were all sisters (mostly those serving in the hospital itself, plus perhaps a representative of the order's council). This arrangement continued through the mid-twentieth century.

Beginning in 1940, most hospitals experienced increased bureaucratization and more lay involvement. This is reflected in the hospital we studied as well. In 1949, the hospital began to pay social security for its lay employees, central purchasing was begun, and an overall hospital committee was created to oversee all departments. In 1950, a lay woman was appointed Clinical Head Nurse, replacing the sister who had held this post. Throughout the 1950s, the hospital board was still composed entirely of sisters, but they were assisted by an Advisory Council of priests and lay men.

Each individual hospital remained autonomous until 1986, when the sisters' National Health System was formed. After this time, the individual hospitals were therefore no longer autonomous; however, the System CEO was a sister, and so were most of the board. By the mid-1990s, however, this was no longer the case. The first lay president was chosen in 1996; and after the formation of the merged health system in 1999, the sisters no longer exercised day-to-day authority over any aspect of the hospital or system operation. Few, if any, of the hospitals in the merged system have CEOs who are members of the founding orders. In fact, even being Catholic is not a requirement for Board membership or leadership at either the System headquarters or its component hospitals. The System, however, does have a two-tier board. The "upper" tier is called the Sponsors' Council and, until recently, it was composed entirely of sisters from the various component orders. Certain powers are "reserved" to the Sponsors' Council, most notably the approval of board nominees, and giving permission for the sale ("alienation") of property.

Relationship with the Bishop/Diocese:

From the beginning, the hospital, like almost all Catholic hospitals, was incorporated to be financially and administratively separate from the diocese in which it was located. While the sisters did consult with the bishop on major decisions (e.g. moving to the new site in 1895), and the bishop sometimes re-routed charitable donations their way, there was no formalized relationship. In many dioceses, the director of Catholic Charities was responsible for acting as a liaison between the bishop and health care institutions. This began to cause problems in the 1930s. By this time, an umbrella sisters' organization, the Catholic Hospital Association, had been founded to help the hospitals professionalize and adopt updated procedures. But the CHA had no official link to the local bishops or to the national bishops' conference, except indirectly through Catholic Charities. Discussions were held whether to give full CHA membership (including voting rights) to "any clergy with responsibility in health care matters." The bishops preferred this, but the sisters in the CHA feared it would lead to "clerical domination and the demise of the CHA as a sisters' organization." As a result, diocesan clergy/bishops were given *associate* membership in the CHA, without voting rights. In 1939 the bishops' group in CHA re-established the position of diocesan director of hospitals across the country. This removed the bishops' threat to CHA autonomy.

As the number of sisters has declined in recent years, the leadership and membership of the CHA has likewise become increasingly lay. The first lay president of the CHA was elected in 1979. This has raised new questions about the Catholic identity of the hospitals and systems, and what, if anything, the local bishops can do to insure its continuance. In 1997, therefore, the National Conference of Catholic Bishops (NCCB) published a pamphlet entitled "The Pastoral Role of the Diocesan bishop in Catholic Health Care Ministry." In this document, the bishops outlined the following roles for bishops:

- Insure doctrinal and moral integrity, and Catholic identity
- Insure celebration of the sacraments in health care settings
- Dialog on alienation of property
- Foster collaboration with Catholic agencies

Relationships with the bishops are generally good; however, since each bishop is supreme in his diocese, this means that Catholic health systems, which span several dioceses, must deal with many different bishops – who each may enforce different health-care policies within his boundaries.



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University of Maryland, Department of Anthropology, 1111 Woods Hall, College Park, MD 20742

Phone: 301.405.7121 Email: faithandorganizations@anth.umd.edu