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Collaboration is Key:

A Study on the Religious Identity of Catholic and Southern Baptist Hospitals

Benjamin German

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Introduction

Since its inception, the Christian church has emphasized physical healing alongside spiritual healing. Christians in the United States have recognized the necessity of caring for a person holistically, both physically and spiritually. The Roman Catholics and Southern Baptists established their first hospitals in America in the mid-nineteenth and late-nineteenth centuries respectively. They both began as movements with the dualistic missions of providing for body and soul. Today, hospitals and health clinics which bear the name Catholic treat one of every six patients in the US, and there are a number of hospitals which still carry the Baptist name.¹ However, name does not necessarily imply continuity. In an increasingly secularized culture, just how many of these hospitals maintain a religious identity consistent with their founding principles? Generally speaking, Roman Catholics have done a better job at retaining their religious identity within Catholic health systems and hospitals.

Due to their sheer numbers, the dedication of their sponsoring religious orders, and the careful oversight of Catholic hierarchy, Roman Catholic hospitals have more consistently succeeded in maintaining their religious identity than Southern Baptist hospitals. Religious orders of women have founded hospitals in abundance, whereas Baptist conventions historically have founded only limited numbers of hospitals. Thus, the latter have had difficulty in forming affiliations with other like-minded institutions. In this era, affiliation is critical for financial viability. Having an abundance of Catholic hospitals simply made it easier for each Catholic hospital to join with a compatible institution than for the sparsely-numbered Baptist institutions to do so. Unequally-yoked

¹ “Facts & Statistics: Catholic Health Care in the United States,” About, last updated Jan. 2015, accessed March 24, 2015, <http://www.chausa.org/about/about/facts-statistics>.

hospital unions often force the religious hospitals into compromise, and this has been a typical trend for Baptist institutions. Second, women religious expressed great commitment to health care as ministry. These sisters have held a significant stake in their institutions maintaining a Catholic mission, and, aided by the Catholic Health Association, they have had good success. In contrast, Southern Baptist state conventions have not inclined themselves towards health care ministry to the same degree as Catholic religious orders have. Third, the Catholic tradition of hierarchy has empowered Catholic hospitals to keep their identity even while affiliating with secular hospitals. Autonomous Baptist hospitals have not duplicated this. Catholic hospitals must submit to the authority of the local bishop to remain Catholic. In contrast, only a few Baptist hospitals have managed to form Baptist health systems, and within secular systems virtually none have held fast to their Baptist moorings. For these reasons, Catholic hospitals have shown a greater resilience in keeping their religious identity than their Baptist counterparts. To truly investigate how this worked out historically, though, one needs to understand the broader historical context of the American healthcare system.

Context

The American hospital system has taken significant strides since 1870. Beginning during this decade, hospitals experienced a transition from almshouses to purported bastions of science. Healthcare had a fairly crude existence in the mid-nineteenth century, and hospitals were little better than homeless shelters. However, as technology began to improve, hospitals transitioned towards clean, well-organized, and advanced institutions.

Many saw hospitals as symptomatic of broader American advancements. With such optimism came increased demand.²

After World War I, American hospitals grew exponentially, and admissions skyrocketed. Medical pioneers developed surgery and obstetrics into a mesmerizing tool, capable of producing quick healing which before could not have been imagined. In the late 1920s, 4 diagnoses were responsible for 60 percent of all admissions, all related to surgery and obstetrics. As new innovations became available, consumers gained greater expectations for the level of medical care they might obtain, and healthcare began its transition to commoditization.³

Consumerism in healthcare significantly impacted the system. First, technology continued to accelerate with the increased demand. More money was spent to develop new technologies which in turn drove up costs. Standardization also took place. The American College of Surgeons began a voluntary accreditation program which had only modest success at first. However, by the mid-1920s it had gained tremendous influence and become the sole hospital accrediting body for hospitals, a title it held until 1951. This voluntary sort of accreditation exemplifies a greater trend within the American healthcare system – that of voluntarism. This phenomenon would play an important role in how the nation dealt with rising healthcare costs.⁴

In response to rising costs of health care, private-third party insurance developed. The goal of the federal government was to make technological advancements accessible to all people. Rather than the federal government providing universal, mandatory health

² Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, (Baltimore: Johns Hopkins University Press, 1999), 17-20.

³ *Ibid.* 106-116.

⁴ *Ibid.*

coverage, the government supported the introduction of Bluecross health plans.⁵ These plans would allow individuals to pay a certain premium for the year and provide them coverage for any expenses. Beginning in 1929, Bluecross grew astonishingly quickly, adding its ten millionth subscriber just a decade later.⁶ This voluntarist approach held in tension the twin goals of technology-driven capitalist expansion and publicly-interested provision of healthcare.⁷

In the years following World War II, these two dreams continued to be sought. From the period of 1946-1965, a vicious cycle ensued. Technological advancements and ever-higher expectations of service drove healthcare costs to excessive heights.⁸ During this timeframe, the average cost of patient care within a hospital went from \$10 to \$44 per day.⁹ Insurance companies passed this ever-increasing cost on to consumers through ever-rising premiums, placing access to an insurance plan out of the grasp of the elderly and the lower class. In response to such a cycle, the federal government stepped into the spot light with President Johnson signing into law the Medicare and Medicaid programs in 1965.¹⁰

Although it instituted the Medicare and Medicaid programs, the federal government still encouraged the private sector to provide care, rather than establishing a truly socialized medical system. The program expenditures increased astronomically over the next fifteen years. In 1980, they had increased to \$35 billion annually, a number nearly half the size of total voluntary, short-term general hospital income. With this, the

⁵ Ibid. 171-175.

⁶ Marc Lichtenstein, "Health Insurance from Invention to Innovation: A History of the Blue Cross and Blue Shield Companies," BlueCross BlueShield blog, accessed Dec. 12, 2014, www.bcbs.com/blog/health-insurance.html.

⁷ Stevens, *In Sickness and in Wealth*, 227-228.

⁸ Ibid.

⁹ Ibid., 263.

¹⁰ Ibid., 256-58.

government gained greater regulative prerogatives with voluntary hospitals. Nonetheless, the federal government still considered the private sector to be the most efficient way to provide healthcare, so it encouraged competition. It incentivized good management, rewarding cost containment. If hospitals garnered a surplus, they were succeeding, but this also called into question whether voluntary, not-for-profit institutions could still retain tax-exempt status. As Rosemary Stevens asserts, there was really little difference between the “for profit” and “not-for-profit” institutions besides their tax status.¹¹ Government policies would continue to play a substantial role in hospital growth.

In the 1990s, hospitals increasingly joined together into health systems. No one wanted to be left out of the new trend. By 1996, over half of community hospitals with more than 200 beds joined a hospital network. Larger hospitals tended to be more likely to join health systems, with a full sixty-six percent of the largest hospitals (500 beds or more) joining such systems. Interestingly, not-for-profit hospitals composed the lion’s share of these systems, combining to form no fewer than two hundred separate systems. For-profits only composed thirteen.¹² Today, the trend towards hospital systems is equally stark. Of all hospitals in the US, seventy percent of hospitals are part of a health system.¹³

Why should hospitals flock to such systems? The ever-rising costs of healthcare combined with insufficient government reimbursement acted as the primary movers. For institutions heavily dependent on Medicare and Medicaid subsidy especially (these programs do not typically cover the complete cost of patient care), these hospitals looked

¹¹ Ibid., 284-6.

¹² Ibid., xx-xxi.

¹³ American Hospital Association, *AHA Guide 2015 (American Hospital Association Guide to the Health Care Field)*, (Chicago: AHA, 2014), B 3. ; American Hospital Association, *AHA Hospital Statistics, 2015 edition*, (Chicago: AHA, 2014), 2.

for any way possible to reduce costs.¹⁴ As the cost of healthcare has increased precipitously, hospitals have required increasing amounts of capital to succeed. Hospitals have needed extra capital on hand to fund day-to-day operations pending delays in government reimbursement. They also have solicited increasingly great sums to begin new building projects or revitalize older ones. As Stevens puts it, “Hospitals had a public mandate – even a social duty – to expand, rebuild, and reequip.”¹⁵ Even in the 1960s and ‘70s, Hill-Burton grants¹⁶ became increasingly miniscule in proportion to the overall cost of hospital construction.¹⁷ This increasing demand for capital since 1965 provided substantial reason for hospitals to move towards health systems.

How can health systems work to decrease costs? One way of doing this is by streamlining services. Ten hospitals netted together could have a central location for IT services, and they ostensibly would not need mid-level administration.¹⁸ Especially for urban hospitals which often care for large numbers of the indigent, hospital systems make the difference between survival and closure.

Because of insufficient reimbursement rates, faith-based hospitals – which were often located in impoverished urban areas – have been caught in a struggle between mission and margin.¹⁹ Finances have of course always been a concern; hospitals are, after all, businesses. However, in days prior to government subsidization, religious, charitable

¹⁴ The most recent statistics show that on average Medicare reimburses only 88 cents per dollar, and Medicare only 90 cents.

American Hospital Association. “Underpayment by Medicare and Medicaid Fact Sheet: 2015,” Financial Fact Sheets, accessed Jan. 20, 2015, <http://www.aha.org/research/policy/finfactsheets.shtml>.

¹⁵ Stevens. *In Sickness and in Wealth*, 294.

¹⁶ Hill-Burton grants were offered by the Federal government beginning in 1946 under the *Hospital Survey and Construction Act* to bolster the number of hospitals in the nation. Grants were offered to existing hospitals either to expand and update existing facilities or to build new hospitals.

¹⁷ Ibid.

¹⁸ Father Marty Hebda, interview by author, March 12, 2015.

¹⁹ Georgine Scarpino, *The Rise and Fall of Faith-based Hospitals: the Allegheny County Story*, (Bloomington, IN: Authorhouse, 2013), 34-35.

hospitals survived – and often barely – through private donations and regular sacrifice of their founders.

With the rise of third-party insurance payers and government funding, these hospitals had a more certain source for income. However they also became more dependent upon these sources for survival. Simultaneously private funding for charitable hospitals decreased in the Medicare era.²⁰ Formerly, religious hospitals catered to a religious constituency as their primary health care providers. Catholics came to Catholic hospitals. However, in a market-based system with ever-increasing specialization, middle-class patients went to hospitals which offered niche care according to their needs. In order to survive, urban hospitals would need to diversify their investments to gain access to a wealthier patient pool.

Many religious hospitals struggled to balance their mission of serving the poor with supporting themselves. They could choose to remain in the urban setting in which they originally planted and grew roots, providing large amounts of indigent care, or they could relocate their facilities to more affluent areas. That Catholic hospitals face this dilemma has been fairly well-documented,²¹ and Baptist hospitals have historically been caught in the same dilemma. Because both types of hospitals sought to follow Christ's example of caring for the poor and needy, both struggled between maintaining mission in the face of margin.

Methodology

²⁰ Stevens, *In Sickness and in Wealth*, 295.

²¹ Kaiser Family Foundation, "Affiliations Between Catholic and Non-Catholic Health Care Providers and the Availability of Reproductive Health Services," 16, accessed March 14, 2015. <https://kaiserfamilyfoundation.files.wordpress.com/1997/10/commonground.pdf>.

This topic may be of particular interest to church denominations who are interested in missional fidelity, especially for their associated ministry organizations. In order to maintain their original focus, these groups must survey their own heritage as well as the histories of other sects to look for potential pitfalls. If they wish for their social agencies to preserve their religious identity, they will have interest in looking at the histories of others. This investigation into the histories of religiously-founded hospitals will be of interest to those who seek to avoid missional drift within their religious denomination or entity.

This paper will investigate this issue primarily using five case studies and supplementing them with other examples. It will trace the history of two Catholic institutions – Mercy Hospital of Chicago and Mercy Hospital in Pittsburgh – and three Southern Baptist institutions – Missouri Baptist Hospital (now Missouri Baptist Medical Center) in St. Louis, Southern Baptist Hospital (now Ochsner Baptist Medical Center) in New Orleans, and Baptist Memorial Hospital (now Baptist Memorial Health System) in Memphis, Tennessee. The Paper will survey how their particular identities and connections with their parent religious denominations evolved over time, and this will be weighed against the broader context of the denominations and their hospital ministries.

Comparing Organizational Structures

Because the nature of this paper is one of comparing and contrasting, it will be wise to compare the organizational structures for Catholic and Southern Baptist hospitals.

Originally, Catholic hospitals in the US were founded and run by orders of women religious. The regional bishop typically commissioned these women to establish a hospital as a ministry of the Catholic Church. They generally received full privilege to govern and manage the hospital. Today, few of these hospitals are still governed solely by women religious, but many are sponsored by their equivalent organization – a Public Juridic Person²² – which may include lay people. Hospital sponsors under Canon Law are required to answer to the authority of the local bishop.²³ For now, the important thing to realize is that religious orders were the primary governing body for Catholic Hospitals.

For Southern Baptist hospitals, the state Baptist conventions generally appointed a board of directors for each hospital. The earliest Baptist health care facilities – the Missouri Baptist Sanitarium and the Tabernacle Infirmary – were founded independent of state conventions, but after catching a vision for health care ministry, state conventions gladly welcomed requests from both to take over administration. The conventions soon began establishing other hospitals of their own. While the Southern Baptist Convention did eventually invest in two hospitals of its own control, the original design (and general trend) was for hospitals to be administered by the states. As will be described later in the paper, the emphasis on autonomy among Southern Baptists had significant implications for their hospitals. For now, however, this paper will examine the Catholic institutions.

²² A Public Juridic Person (PJP) is a sponsoring organization for Catholic hospitals. Originally under Canon Law, Catholic hospitals needed a Religious Order to sponsor the institution, taking charge over its identity and general maintenance. In recent years, the Catholic Church has approved a new sort of entity for sponsorship, one which includes laity in its leadership. This new type of organization is known as a PJP.

²³ Catholic Health Association, “Ministerial Juridic Person: The Growing Role for Laity in Canonical Sponsorship of Catholic Health Care,” *Health Progress*, no. 5 (September-October, 2014):.60-61, accessed March 14, 2015, <https://www.chausa.org/publications/health-progress/article/september-october-2014/ministerial-juridic-person-em-the-growing-role-for-laity-in-canonical-sponsorship-of-catholic-health-care-em>

Catholic Hospitals

There are 645 Catholic hospitals in the United States.²⁴ In the modern health care system, they are affiliated with each other and other hospitals in numerous ways.

However, Catholic hospitals generally still have a strong sense of cohesion and common identity. What are the components of this identity? Friar Morrisey writes: “There are many ways of being ‘Catholic,’ and no single approach can claim superiority over the others.”²⁵ There has been significant debate since the 1970s over the exact requirements for a hospital to be Catholic in nature.²⁶ In a strict legal sense, it simply requires the regional bishop’s oversight and approval.²⁷ However, the bishop himself must have qualities he looks for in determining a hospital’s catholicity.

Morrisey argues that there are four general qualities which Catholic hospitals must exhibit. First a Catholic hospital must be committed to the Biblical Ethics. Generally speaking, the moral criteria for Catholic health decisions are spelled out in the *Ethics and Religious Directives* (ERD) handed down by the Vatican. This is the most obvious criterion, and essentially every Catholic hospital adheres to it. The second quality is Mission. With this trait, there is a great deal of latitude. The hospital’s mission should be compatible with the mission of the Church, to manifest Christ’s love and saving mission to the world.²⁸ It is sacramental living, being the sign of the presence of Christ.²⁹

²⁴ Catholic Health Association, “Facts & Statistics: Catholic Health Care in the United States,” About, accessed March 23, 2015, <http://www.chausa.org/about/about/facts-statistics>.

²⁵ Fr. Francis G. Morrisey, “Catholic Identity in a Challenging Environment,” *Health Progress* 80, no. 6 (November-December 1999): 39, accessed March 14, 2015, <http://www.chausa.org/docs/default-source/health-progress/catholic-identity-in-a-challenging-environment-pdf.pdf?sfvrsn=0>.

²⁶ Karen Sue Smith, “Caritas in Communion: a Summary,” (St. Louis: Catholic Health Association, 2013), 3-4, accessed March 14, 2015, <http://www.chausa.org/docs/default-source/default-document-library/caritas-in-communion---summary.pdf?sfvrsn=2>

²⁷ Morrisey, “Catholic Identity,” 39-40.

²⁸ Ibid.

²⁹ Smith, “Caritas in Communion,” 4.

Third is through Sponsorship. Sponsors exist under Canon Law as the endowed entity with representational authority and oversight over the hospital, and in legal terms they are a juridic person. Essentially, this component links the institution back to the Catholic Church. In an era when hospitals are constantly changing in affiliation, Morrissey sees this quality as quite flexible, yet he thinks some level of accountability is non-negotiable. Last is Holistic Care. A distinctly Catholic hospital must keep its focus on the whole person, and this requires intentional mechanisms for spiritual care. He also notes that such care should be for people of any faith.³⁰ As Karen Sue Smith of the Catholic Health Association puts it, “To witness does not mean to proselytize,...Witness is the way Catholic health care, by continuing God’s healing work, invites people to God.”³¹

Morrissey argues that these four, semi-fluid qualities must be present in some way. Otherwise, a Catholic hospital is not present. While Smith’s summation is not quite so systematic as Morrissey’s, she adds charity care for the needy as another necessary distinctive for Catholic hospitals.³² Though Morrissey does not mention indigent care particularly, giving is an obvious manifestation of God’s love, the mission of the Church. He would probably be comfortable adding this quality to the list. With these basic tenets of Catholic health care, this paper will turn to the actual hospitals

The Sisters of Charity began in October 1823 to staff the Baltimore infirmary under the direction of Baltimore University medical staff. This was the first true hospital-like infirmary for which Catholic sisters performed nursing duties. The Sisters had been founded in 1803, and none of the five who arrived to staff the Infirmary had any training

³⁰ Morrissey, “Catholic Identity,” 40.

³¹ Smith, “Caritas in Communion,” 4.

³² Ibid, 3.

in nursing. Nonetheless, they heartily undertook the endeavor as an opportunity to care for the poor and sick.³³

From the start, these Sisters displayed a deep interest in caring holistically for their patients. Their mission statement as a religious order stated that their intentions were “to honor our Lord Jesus Christ as the source and model of all charity, by rendering Him every temporal and spiritual service in their power, in the persons of the poor, the sick, prisoners and others.³⁴” Catholic sisters made the natural extension from their care for the poor to hospital ministry. Mother Clark, who had been appointed assistant to the founder in 1821, helped to further formalize expectations for Sisters of Charity as nurses. Her nursing handbook set clear goals for holistic care: “The union between the soul and the body is so close that when the latter is suffering a great deal, the other, attentive to its wants, cannot think of anything else.” She believed that in caring for their physical needs first, they would seek attention for spiritual needs.³⁵ Thus, Catholic hospital care originated with sisters who had a holistic mission for care, especially for the poor.

Though the Baltimore Infirmary was staffed by highly-trained physicians, they still had quite limited medical knowledge. The majority of hospitals did not have even this level of accommodations. Catholic hospitals, though more like almshouses, continued to grow in number. In 1872, there were 75, but by 1910, there were nearly 400.³⁶ As mentioned before, medical technology was advancing at a breakneck pace, and hospitals were growing in size and numbers. With such growth, came standardization. The dilemma was that Catholic hospitals had no mechanism in place to support a uniform

³³ Christopher Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States*, [New York: Crossroad, 1995], 33-34.

³⁴ *Ibid.*, 34.

³⁵ *Ibid.*, 37,40-41.

³⁶ *Ibid.*, 130.

standardization movement. Sensing the need for greater unity, Father Charles Moulmier from Marquette School of Medicine found a solution.

In April of 1915, Father Moulmier brought together thirty-five sisters from the upper mid-west to form what became known as the Catholic Hospital Association. It was the standardization movement that primarily drove Moulmier to found the CHA. While he wanted them to stay abreast of technological advancements, he also feared that patients would soon be ignored as the hospital became an impersonal, whitewashed institution of science. The CHA would work to educate Sisters and serve as a touchstone for the exchange of ideas and needs. Moulmier also made a point to gain approval from the Catholic Church.³⁷

Even before their first meeting, he sought approval from Archbishop Messmer. Messmer expressed such enthusiasm for Moulmier's proposal that he sent an open letter to all the superiors of women religious, asking them to send representatives to attend a CHA meeting. Messmer proved an invaluable asset to the fledgling organization when a number of bishops and other Catholics expressed concerns. Some feared that the hospitals would become secularized as they tried to adapt to the new hospital climate. Others feared that while the Sisters were being educated in according to the secular standards of the day, they would be gradually enticed away from the Catholic Church, eventually stripping the hospitals of their catholicity. Some even believed that teaching a sister anatomy and physiology would taint her virtue. Messmer personally responded to these concerns and others, arguing that though the Catholic Church was inherently conservative, yet it needed to meet the challenges of the day through modern tools. To the latter complaint about learning anatomy, he quipped that such a sister had no business

³⁷ Ibid., 169-71.

in a hospital. She either “ought to gain entrance into another order or ask the superiors to send [her]... thence to the kitchen, where she may study the anatomy of the chicken.”³⁸

With such support from Messmer, the CHA was on sure footing as it began its work.³⁹

With such wholesale acceptance by Catholic leaders, it is not surprising that the CHA prioritized holistic care. At the 1922 CHA convention, Father Moulmier praised Catholic hospitals because “four million patients each year are receiving help for body and soul... Who will tell us how many of those four million patients, who pass into eternity owe their salvation to the prompting of a sister’s hospital?”⁴⁰ The next president of the CHA, Alphonse Schwitalla (1928-47), also emphasized holistic care. He argued that every situation in a hospital had spiritual significance in pushing souls towards or away from eternity.⁴¹ This is clearly a demonstration of the sacramental living which is a mark of Catholic healthcare.

During Schwitalla’s presidency, a profound struggle began to emerge in Catholic health care, a struggle between Catholic idealism and secular progress. The real battle for sisters was between viewing health care as a sacred vocation or a public profession. They felt increasing pressure in Post-World War II America to leave their sense of hallowedness within to the hospital walls, and to replace it with a professional atmosphere.⁴² Schwitalla himself illustrates the struggles felt by the women religious and their respective hospitals, attempting to walk the tight line between retaining Catholic identity and moving forward with standardization. For example, Schwitalla had sought to create a Catholic nursing accreditation body. However, he received strong pushback from

³⁸ Ibid. 175-76.

³⁹ Ibid., 175-76.

⁴⁰ Ibid., 189-90.

⁴¹ Ibid., 224

⁴² Ibid., 244.

some of religious orders to instead use the secular National League of Nursing Education for accreditation. After long battle, Schwitalla retired and the next CHA president approved using the NLNE.⁴³

As it did for the rest of Catholicism, Vatican II brought tremendous changes to Catholic health care. Among its changes was the issuing of a Vatican document called the Dogmatic Constitution of the Church, *Lumen Gentium*. The practical outworking of this document resulted in a partial leveling of the Church, emphasizing more collegial relationships between levels of hierarchy. Nuns were now permitted to request where they be sent for ministry by their superiors. Some religious orders even opted to relinquish their hospitals altogether in order to focus on social justice issues by different means.⁴⁴ A good number of women religious began to identify to some degree with the liberation ideals of the feminist movement. As a result of this greater latitude to choose their own avenue for ministry, women religious in healthcare began to decline precipitously.⁴⁵ Between 1965 and 1975, Catholic hospitals declined in number from 803 to 671.⁴⁶ Simultaneously, women religious involved in health care dropped from 13,618 to 8,980.⁴⁷ Vatican II also removed part of the divide between religious orders and laity. Now, laity were encouraged to partake in sacramental ministry beside religious orders. With the dwindling of women religious connected to health care, hospitals would need committed lay people to take up the mantle of the sisters.

⁴³ Ibid., 218-235.

⁴⁴ Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions*. (Piscataway, NJ: Rutgers University Press, 2011), 9.

⁴⁵ Kauffman, *Ministry and Meaning*, 284.

⁴⁶ CARA, "Frequently Requested Church Statistics," Services, accessed March 23, 2015, <http://cara.georgetown.edu/CARAServices/requestedchurchstats.html>.

⁴⁷ Kauffman, *Ministry and Meaning*, 285.

Just after Vatican II, the CHA began to emphasize hospital systems. Appointed as CEO for the CHA in 1971, Sister Mary Maurita Sengelaub sought diligently to help Catholic hospitals affiliate more closely together by proposing new methods for hospital sponsorship. For Sengelaub, hospital systems would be most effective if the sponsoring religious order had direct ownership over the multiple hospitals. Under her leadership, the CHA also reorganized to include a department devoted especially to helping hospitals retain their identity.⁴⁸ While Vatican II had caused quite a stir in Catholic health care, the CHA demonstrated remarkable foresight as it sought to help hospitals make the transition.

Mercy Pittsburgh

A survey of Catholic hospital history already reveals some of the common threads of how they preserved their identity. However, it will be helpful to look at the histories of individual hospitals as case studies.

In 1831, Catherine McAuley founded the Sisters of Mercy in Ireland. McAuley, bereaved of her wealthy parents at a young age, was eventually able to use her family's estate to construct an almshouse which she operated. After being given permission to start a religious order, she eventually became the head of over one hundred Sisters. Two years after her death in 1841, her closest friend Mother Mary Frances Xavier Warde made the taxing journey to the city of Pittsburgh. It was here that the Sisters would found the oldest hospital in the US – Mercy Hospital – in 1847. Just three years after arriving

⁴⁸ Ibid., 296-7.

in Pittsburgh, Mother Warde chose five Sisters to move to the small but burgeoning coastal town of Chicago, and in 1852, these young Sisters chartered Mercy Hospital.⁴⁹

It was Pittsburgh's Bishop Michael O'Connor who proposed that the Sisters of Mercy build a hospital. For funds, O'Connor requested that the priests for the three local parishes take donations, and he also enlisted a number of lay business leaders to help raise support.⁵⁰ The newly formed women's auxiliary also did a great deal to help with fundraising, a role they continued to hold for decades.⁵¹ When the hospital opened in 1847, it charged three dollars per week for ward care and five dollars per week private room, both of these including medical attention. Leeching could be purchased for an additional dollar.⁵²

The Sisters demonstrated tremendous sacrifice as they strove to care for patients and keep the doors open. In 1848, typhoid fever began to plague some of the coastal US cities, and shortly thereafter a few cases drifted on the waterways into Pittsburgh. Because they determined the hospital was not prepared yet to handle cases of contagious disease, hospital authorities shunned anyone infected. Nonetheless, an infected patient was admitted undiagnosed. Within a month, four sisters had succumbed to the disease as they cared for patients. Nonetheless, service at Mercy continued steadfastly.⁵³ In 1855 under the authority of the bishop, control of the hospital was transferred from a lay board to the Sisters. However, far from financially stable, the hospital survived solely on

⁴⁹ Mercy Hospital, "Still Serving Chicago; Still Living the Mission," Our History, accessed March 14, 2015, <http://www.mercy-chicago.org/legacy/history>.

⁵⁰ Mercy Hospital (Pittsburgh, Pa.), *The Footprints of Mercy, 1847-1947*, (Pittsburgh: Mercy Hospital, 1950), 30.

⁵¹ M. Cornelius Meerwald, *History of the Pittsburgh Mercy Hospital, 1847-1959*, (Unknown, 1961), 44.

⁵² Mercy Hospital, *Footprints of Mercy*, 31.

⁵³ *Ibid.*, 31-32

voluntary contributions. It truly was a charitable endeavor. For example, in 1857, 172 of 232 patients received free care; only 40 paid in full.⁵⁴

Though it struggled through fierce financial difficulty, the hospital stood fast to its mission. Early on, the Sisters commonly stated this mantra: “One – only one steadying fact persists – the fact of GOD. It was to the service of God and the service of man – the whole man, soul and body, - that Mercy Hospital was founded in 1847.”⁵⁵ During a particularly difficult financial crunch in the 1870s, the state of Pennsylvania began granting funds to Mercy. However, in 1921, despite the hospitals generally pluralistic attitude (it would care for any patient regardless of creed or color), the state withdrew its funding because it deemed the hospital to be sectarian. Some advised the Mother Superior to remove religious symbols from the hospital that it might again seek state aid, but Sister Innocent declined.⁵⁶ The hospital would not change its identity.

During the first half of the twentieth century, Mercy Pittsburgh was a stalwart provider of healthcare, considered to be one of Pennsylvania’s finest hospitals, but after University of Pittsburg decided to train students in its own facilities, the hospital’s influence diminished. During its glory days, patients sought after the hospital for its medical specialties. However, though Mercy lost some of its medical stature, it retained its focus of providing charity care during the period. In 1953, for example, its outpatient clinic treated 23,000 patients without charge. Although its more affluent patients began to move to the suburbs, Mercy remained in the center of the city.⁵⁷

⁵⁴ Ibid., 33-35.

⁵⁵ Ibid. 45.

⁵⁶ Ibid., 39, 44-45.

⁵⁷ Wall, *American Catholic Hospitals*, 41-43.

During the twentieth century, Mercy Pittsburgh had a number of governing models. Until 1913, it had been directed by a lay board, but it then shifted towards leadership by the local Sisters. By 1947, they held sole governing authority.⁵⁸ A number of other changes took place until eventually, Mercy reorganized in 1983 to form the Pittsburgh Mercy Health System (PMHS), an entity encompassing multiple Mercy holdings in the area. While Mercy Hospital was faring well financially, other hospitals which Mercy added to its system began to drag it down. While it posted a net income of \$3 million in 1993, other members suffered financial losses.⁵⁹ As Mercy lost ground in the local market, University of Pittsburg Medical Center (UPMC) sought to gain a presence in all health care markets in the state, buying up numerous hospitals. That same year in 1996, hospital occupancy rates had dropped to sixty-one percent, and in a very volatile climate, numerous area hospitals went bankrupt. After faring reasonably well in spite of this, Mercy Hospital began to post financial losses in the 2000s. PMHC could not save Mercy without bringing the rest of its facilities into bankruptcy also, so it made a daring move: it entered negotiations with UPMC.⁶⁰

The 2008 negotiation with UPMC yielded a very interesting agreement: a Catholic hospital owned by a secular health system. The negotiations resulted in two separate contracts, one between Mercy and UPMC and the other between Mercy and the local Catholic diocese. The secular contract gave UPMC control over the hospital's daily affairs and personnel. The Catholic agreement essentially made the bishop the official sponsor of the hospital and contained a number of mandates to ensure the Catholicity of the institution. Among these were a required submission to the ERD, a strong spiritual

⁵⁸ Ibid. 43.

⁵⁹ Ibid. 44

⁶⁰ Ibid. 45-46

care department, an official vice president of mission who must conduct mission assessments biennially, a high level of continued charity care, and three board members appointed by the bishop. The negotiation left Mercy a generally catholic hospital much as it had been before.⁶¹⁶² According to the most recent mission assessment carried out by the current vice president of mission, the hospital's commitments appear to remain the same.⁶³

In large part because of the persistent self-sacrifice of the hospital Sisters, Mercy Pittsburgh has largely kept its initial mission to date. Even when they gave up administrative control of the hospital in 1965 to a lay board, the Sisters remained at the center of the hospital's mission.⁶⁴ In the words of one Sister of Mercy, "The Sisters were always there hidden 'within the clockworks,' as it were, 'making the wheels go round.'"⁶⁵ From the hospital's earliest days, they set the tone for holistic care for the poor. During the years leading up to the 2008 sale, the sisters exerted force in administrative roles including by Sister Joanne Marie who served for nearly 25 years. Today, there are only a handful of sisters still employed at the hospital, but they still exert a disproportionately large influence towards retaining the hospital's identity.⁶⁶ Certainly, the hospital's sponsorship by the bishop and the legal agreement is of immense importance. However, time will tell if the legacy of the Sisters can be transmitted to the lay workers who have

⁶¹ Phyllis Grasser, interview by the author, February 19, 2015.

⁶² Draft [Summary Document of the Mercy-UPMC Contract Concerning Catholic Identity], 1-2.

⁶³ Phyllis, Grasser, UPMC Mercy Mission Assessment 2013, 3-16.

⁶⁴ The property to the hospital was still owned by the Sisters of Mercy Corporation, and thus they still retained sponsorship through the process in accordance with Canon Law. Additionally, the Sister's received approval from Father Flannigan, President of the CHA, and by the Pittsburgh Bishop John Wright. Jeanette Rafferty, *Mercy Hospital, 1847-1972: an historical review*, (Unknown, 1972), 68-70.

⁶⁵ *Ibid.*, 75.

⁶⁶ Phyllis Grasser, interview by the author, March 10, 2015.

replaced them at Mercy Pittsburgh. The transfer document has established the right structures for this to take place. For now, it continues to be a very catholic hospital.

Mercy Chicago

Similar to Mercy Pittsburgh, Mercy Chicago moved forward from quite humble beginnings. Originally, the Sisters of Mercy focused on education and care for the poor. All being under age twenty-five, the five young women who had elected to first serve Chicago established both free parochial schools and Agatha's academy. The latter, a *select* school for girls, required tuition, and it was money taken from Agatha's which soon served to fund the hospital early on. The hospital itself was founded in 1848 by businessmen as a teaching hospital for Rush Medical College. These businessmen soon discovered, however, that the physicians in training did not have time to properly nurse the patients. Who were the likely candidates for such an endeavor? Of course it was the Sisters. At first, the Mother Superior declined their proposition, but upon further consideration, she accepted as a new means to care for Chicago's poor. In 1851, the Physicians signed the hospital over to the Sisters, both parties feeling pleased.⁶⁷

After experiencing some growth, a propitious change came for the hospital. For dubious reasons (probably a combination of his failing health and frustration that the hospital was being administrated by women), Bishop James Duggan abruptly demanded in 1863 that the Sisters vacate their hospital; he gave them two days' notice. They moved to a location at the outskirts of town and received immediate mockery because of its

⁶⁷ Joy Clough, *In Service to Chicago: the History of Mercy Hospital*, (Chicago: Mercy Hospital, 1979), 10-18, 24.

distance from the heart of the city. However, 8 years later when 100,000 people lost their homes to the Great Chicago Fire, it began to seem a wise business move. The hospital gained a superb reputation with the city after it cared for 369 patients in the aftermath of the fire.⁶⁸

While the hospital gained prestige in the Chicago community for its efforts, it still had financial challenges. Large debts accrued in the years after the Fire, and in 1876, the Sisters placed the hospital up for auction. However, working with Bishop Thomas Folley, the Chicago diocese temporarily purchased the hospital until the Sisters could earn sufficient funds to pay off the debts. When the Sisters had repaid all but ten thousand dollars to the diocese, the Bishop forgave the rest of their debts. Mercy would continue its service.

Mercy Chicago experienced both highs and lows over the first half of the 20th century. In 1950, the landscape of Chicago had changed drastically since the Sisters originally moved to the edge of town. Their location was now highly urbanized and slum-like, and their facilities were becoming outdated. In recognition of this, it announced plans to move to a new location, a 27 story building located on the north side of town. Out of thanks for all the Mercy had meant to the city, the mayor pledged to raise funds for construction of a new hospital. However, two years and 2.5 million dollars of fundraising later, Mercy announced that it had changed its mind on the property and would search for another location.⁶⁹ From its financial advisors, Mercy was told it would be more economically savvy to move to the suburban havens at the outskirts of the city. Here it would be safer for nurses at night. In the end, however, Mercy ultimately decided

⁶⁸ Ibid., 24-25, 33-35.

⁶⁹ Clough, *In Service to Chicago*, 72-74.

to build a new hospital on a tract of land in the ghetto of the city. It had committed to help the needy through health care, and it would betray this mission by moving.⁷⁰

Staying in an impoverished location was not easy, but Mercy still remained an independent safety-net hospital, caring for those who would have had no guarantee of healthcare otherwise. In 1975, Mercy did shift its organizational model. Perhaps in response to changes after Vatican II, the Sisters created a Members of Corporation. This entity, comprising Sisters appointed by the Provincial Administration of Sisters of Mercy, had authority over the hospital's mission, identity, and general direction. It also appointed the members of the Board of Directors which in turn had authority over the everyday affairs of the hospital. In this way, the Sisters could determine the overall direction of the hospital without needing a large number of Sisters to help.⁷¹ As numbers of Sisters associated with the hospital began to decline, this integration of the laity proved invaluable.

The numbers of Sisters in the Chicago area after Vatican II continued to decline, but the hospital still managed to retain its identity. In the five succeeding years, the Sisters lost a net eighty-five members. By 1991, there remained only 38 who still participated in healthcare at Mercy, 19 of which were aged 60 to 70.⁷² However, the few Sisters who did remain exerted a tremendous influence on the culture and identity of the hospital. As Mary Beth Frazier Connolly notes, these Sisters, especially acting out of

⁷⁰ Ibid., 75-77.

⁷¹ By-Laws of the Sisters of Mercy Hospital and Medical Center (Revised 1975).

⁷² Mary Beth Fraser Connolly. *Women of Faith: the Chicago Sisters of Mercy and the Evolution of a Religious Community*. (New York: Fordham University Press, 2014), 129, 227, 322.

leadership positions, were the primary movers in retaining their Catholic identity.⁷³ The hospital remained under the control of the Sisters until a new chapter opened in 2011.⁷⁴

In 2011, Mercy released a statement expressing intent of merging with Trinity Health Network. Trinity itself was a fairly recent organization, having been formed by two health systems sponsored by Holy Cross Health system and Mercy Health System. The new system was officially launched in 2000 after receiving approval from the Vatican to form a Public Juridic Person.⁷⁵ This new form of Catholic health care sponsorship allowed for a public entity comprised of lay people to act in the same capacity as a religious order would. It would function as the authority structure which ensured Catholic identity. Trinity's founding mission statement included a commitment to holistic care "in the spirit of the Gospel,"⁷⁶ and it expressed earnestness in retaining Catholic identity, seen in its founding principles: "Trinity Health will be committed to the integration, assessment and development of mission in all of its activities, decisions and strategies."⁷⁷ With this merger, Mercy Chicago was able to maintain its missional trajectory.

Mercy Chicago was founded with the intention of providing holistic care for the poor and needy, and in its current state as a subsidiary of Trinity Health Network, it has retained its mission. Today, Mercy's stated mission is to embody "the healing ministry of Jesus Christ that makes visible the love of God... [it] fosters an environment of healing and excellence to the diverse communities it serves."⁷⁸ Though it was often a difficult

⁷³ Ibid., 232-3, 322

⁷⁴ Father Marty Hebda, interview by the author, March 2015.

⁷⁵ Trinity Health, "Filled with Outrageous Hope," Trinity Health, 2-6.

⁷⁶ Ibid., 8.

⁷⁷ Ibid., 9.

⁷⁸ Mercy Hospital, "The Mission," accessed March 24, 2015, <http://www.mercy-chicago.org/legacy/mission>.

choice, it made a point to continue caring for the indigent. To do this has required careful and incessant evaluation of its goals and careful oversight by its religious and lay leadership. Father Marty Hebda, Vice President for Spirituality and Mission at the hospital from 1985 to 2014 stated that under his ministry, Mercy had success because it carefully applied the Ethical and Religious Directives and strove to continually place its mission before employees. Hebda acknowledged the importance of CEO Sister Sheila Lyne in practically carrying out the mission.⁷⁹ Mercy represents a reality of a great many Catholic hospitals who have continued their Catholic identity.

Catholic Affiliations

In an era of hospital affiliations, Catholic hospitals have generally retained their mission. To accomplish this, they have often undergone unique partnerships. A significant number have actually entered into partnerships with non-Catholic hospitals. From 1990 to 1996, Catholic hospitals underwent 131 affiliations, nearly 80 percent of which were with non-Catholic organizations.⁸⁰ A notable example took place in Austin, Texas.

The Seton Medical Center, sponsored by the Daughters of Charity, originally agreed in the 1990s to take over Breckenridge hospital. Breckenridge, a large community hospital, was integral in providing care for indigent of the area. Seton agreed to pay \$10m up front, plus \$2.2m annually to lease the hospital, but while Seton made this decision out of concern for the community, it ran into an ethical dilemma. Breckenridge provided

⁷⁹ Father Marty Hebda, interview by the author March 2015.

⁸⁰ Kaiser Foundation, "Affiliations between Catholic and non-Catholic Health Care providers," 16.

women's health services which violated the ERD. Initially, leasing the property did not make Seton morally complicit because the ERD did not prohibit an indirect role in providing care. However, upon further review, the Vatican took issue with Seton's decision in 1997. A gridlock ensued between the local Bishop and the Vatican until in 2001 the ERD was updated to address the situation. To comply with the new rules, Seton arranged to move reproductive services to separate floor, create a hospital within a hospital, and return the new entity to Breckenridge ownership.⁸¹ The community retained its charitable care and Seton remained Catholic. Significantly, the Catholic hierarchy brought stability to the situation. While a number of Catholics dissented from the Vatican's view, nonetheless the Catholics maintained a united front. This Seton example demonstrates both a Catholic commitment to healthcare and to certain characteristics – most significantly here, the ERD – which unite Catholics together.

Catholic Hospitals: Some Conclusions

A number of factors have contributed to Catholic Hospitals retaining their identity. First, women religious have had remarkable interest in health care as ministry, as evidenced by the myriad of Catholic hospitals existing today. Demonstrated in both Pittsburgh and Chicago, the Sisters of Mercy fully committed themselves to their work and became intimately intertwined with their hospitals. They did not merely treat it as a day job; it was their life. The sacrifices of the Sisters noted above are not merely isolated instances. Rather, they illustrate a culture which unifies their hospitals in mission. Coalescing around the common religious commitments of their order, the sister's beliefs

⁸¹ Wall, *American Catholic Hospitals*, 159-169.

had powerful and practical results. They were the confluence of theory and practice, a group unified by both their Catholic identity and their hospital work. This is not to say that Catholic hospitals have never disagreed or deviated under the watch of women religious, but it is to say that generally they maintained their hospital mission. Their greatest challenge came with diminishing members.

The sisters needed to fully engage laity in their mission. Following the advice of the CHA, they established oversight checks to regularly review how well they were measuring up to their Catholic identity. Sisters also exerted a strong influence in their hospitals through leadership roles and by exemplary daily faithfulness. Even in Trinity Health, now sponsored by a PJP, one quarter of the total members on the Board of Directors and Members of Sponsorship are sisters.⁸² In each of the three largest Catholic health organizations – Ascension Health, Trinity Health, and Catholic Health Initiatives – are PJPs, lead primarily by laity. Nonetheless, each of the hospital systems has perpetuated the tradition of the sisters, taking intentional steps to safeguard their Catholic heritage.⁸³ While women religious laid the groundwork and maintained Catholic hospitals throughout most of the twentieth century, their hospitals began to collaborate with other institutions by necessity, often affiliating in ways which would challenge its Catholic

⁸² Trinity Health Network, “Board of Directors & Members of Catholic Health Ministries,” About Us, accessed March 14, 2015, <http://www.trinity-health.org/board-of-directors>.

⁸³ Ascension uses their own Catholic Identity Matrix to regularly assess their identity as an organization.

Ascension Health, “Catholic Identity Matrix,” Mission Integration, accessed March 24, 2015, http://www.ascensionhealth.org/index.php?option=com_content&view=article&id=342&Itemid=276.

Trinity States that it continually seeks to reflect on its Catholic identity as they strive to exercise it. Trinity Health Network, “Our Catholic Identity,” Our Sponsor, accessed March 24, 2015, <http://www.trinity-health.org/our-sponsor>.

At Catholic Health Initiatives, members from the previously sponsoring religious orders have a number of appointed ways in which they exercise influence still in the organization. Catholic Health Initiatives, “Sponsorship,” About Us, accessed March 24, 2015, <http://catholichealthinit.org/sponsorship>.

identity. These hospitals and their parent religious orders needed assistance to think through how to practically maintain their Catholic identity through mergers and affiliations, a need which the Catholic Health Association has helped to fill.

The Catholic Health Association served as a touchstone for the exchange of ideas. Of the 645 Catholic hospitals in the US today, over 600 of them are members of the CHA.⁸⁴ Historically, the CHA gave Catholic hospitals a united front as it sought standardization, but the CHA has also served in a general advisory capacity. At Mercy Pittsburgh, when they were considering the transition from a religious to a lay leadership board, they asked CHA President Father Flannagan for his opinion.⁸⁵ Since about 1970, the CHA has also served as an invaluable resource for hospitals in keeping their identity. Today, they offer training for mission directors at hospitals. While the Catholic hospitals have benefited immensely from the collaborative expertise of the CHA, they have also needed accountability. When a Catholic hospital affiliates with a secular hospital – one which does not share its values or mission – the Catholic institution must often make certain concessions with its partner, concessions which may not accord with their Catholic identity. Some outside authority figure is required clearly establish and enforce Catholic identity. For this purpose, the local bishop invaluablely asserted his ascendancy.

Catholic hospitals have received necessary stability through the oversight of the local bishop who functioned as a liaison between the hospital and the Church. In a theoretical sense, he guaranteed the catholicity of the hospital; he had the outright authority to grant or revoke an institution's association with the Church. This clearly-delineated system of catholicity yielded the sort of stability necessary for an institution to

⁸⁴ Catholic Health Association, "Facts & Statistics."

⁸⁵ Rafferty, Mercy Hospital, 68-70.

keep its mission. The bishop, a part of the Church, could not help but be Catholic; as long as he stayed true to the Church, the hospital's identity could not be anything but clear. If the bishop saw the hospital drifting from its mission, he could revoke catholicity. Such a black-and-white hierarchy explains how Catholic hospitals can be so uniformly bound by the ERD. This is not to say that the bishops have been inflexible. In the Seton example, the local bishop actually permitted the hospital to lease Breckenridge's reproductive services. However, after the Vatican amended the ERD, Seton, albeit begrudgingly, submitted to Catholic authority. In an institution that entangles itself so thoroughly in public life, such rigidity begets identity. For these reasons, Catholic hospitals have in large part taken one of two paths: retain their mission or lose their Catholic status. However, to be balanced, a hospital also needs practical solutions to life's complexities, and the CHA provided this.

Southern Baptist Hospitals

Today, Southern Baptist state conventions govern approximately twenty-three hospitals and health facilities in the US.⁸⁶ This number pales in comparison to the number of Catholic facilities. When one notes that 22 of these facilities are part of just two health systems, the comparison is even starker. State conventions continue to support just three hospital groups. It is certainly true that Southern Baptists never amassed a number of health care facilities even close to that of Catholics, but even so, compared to 1970, when

⁸⁶ Baptist Memorial Health Care has fourteen locations. Baptist Health System in Mississippi contains 9 locations. According the Baptist General Convention of Texas, the state convention appoints a majority of trustees for Hendrick Health System in Abilene, TX.

Southern Baptists supported 41 hospitals, numbers have declined severely.⁸⁷ However, though no longer linked to conventions, a number of other hospitals still retain the name Baptist. Are they still Baptist institutions by identity or by name only? While the story of these Baptist hospitals is not a simple one, there are a few trends which hold true nearly universally. In general, only Baptist hospitals which have remained connected with their convention have sustained their Baptist identity.

Southern Baptist hospitals found unity in a few general qualities. Ironically enough, Baptists found unity in their autonomy. Theologically, Southern Baptists subscribe to a congregational form of church government. Each local church votes individually to appoint its leadership. Local churches may affiliate to form local Baptist associations, many of which in turn collectively form state conventions. Each of these conventions then sends a number of messengers to represent them in the Southern Baptist Convention. In contrast with the hierarchy of the Catholic Church which finds its authority in the Vatican, Baptists place most of their authority at the level of the local church. One can see this same autonomy exercised in Baptist hospitals.

The earliest Baptist hospitals were founded by individuals and local Baptist associations. Dr. William Mayfield and the local Baptist ministers association founded the Missouri Baptist Sanitarium in 1887, the first Southern Baptist hospital.⁸⁸ In 1903, Dr. Len Broughten, pastor of the Georgia Tabernacle founded the Tabernacle Infirmary, a second Baptist institution.⁸⁹ As hospitals grew in number, the Southern Baptist

⁸⁷ Author unknown, "Executive Committee Proposes Hospital Divesture," *Baptist Press*, February 17, 1970, accessed March 6, 2015. <http://media.sbhla.org.s3.amazonaws.com/2943,17-Feb-1970.pdf>.

⁸⁸ Betty Burnette, *One Hundred Years of Caring: Missouri Baptist Hospital, St. Louis*, (St. Louis: Missouri Baptist Hospital, 1987), 3-5.

⁸⁹ Southern Baptist Historical Library and Archives: AR-171 Baptist Hospitals Collection, 1.19 "History."

Convention (SBC) planned for state conventions to bear responsibility for all Baptist hospitals.⁹⁰ The SBC finally birthed its first hospital in 1925. As will be seen later, a number of conventions released their hospitals because they felt the institutions could operate better without the encumbrance of convention leadership. Clearly, then, autonomy played a role in defining the Baptist hospital movement.

Rooted in the ministry of Christ, Southern Baptists found unity in their emphasis on holistic care with an earnest desire for evangelism. The Proposed Program Structure for Southern Baptist Hospitals stated its mission this way: “A Baptist hospital exists to bring men into a saving relationship with God through faith in Jesus Christ by means of direct personal witness as occasion presents... [it] Makes available the full resources of the hospital to those people least able to pay in such ways as to preserve human dignity and worth.”⁹¹ It was for the dual purposes of healing sick and relieving suffering while healing souls and bringing sinners to repentance.⁹² Compared to Catholic hospitals, though, both types of institutions were thoroughly holistic in their care, Baptist hospitals seem to have been more forthright in their evangelism in their early years of existence. Some Baptists hospitals would use the PA systems and radio to deliver gospel messages to their patient’s bedsides.⁹³ Baptist hospitals also aimed to train Christian health care workers for service.⁹⁴ Carrying out the three-fold mission of Jesus – healing, preaching, and teaching – was a common refrain for Baptist hospitals.⁹⁵ While they found their

⁹⁰ SBHLA: AR-171 Baptist Hospitals Collection, 1.34 “Proposed Program Structure – Southern Baptist Hospitals,” 2-3.

⁹¹ SBHLA, “Proposed Program Structure,” 4.

⁹² Southern Baptist Convention, *Annual of the Southern Baptist Convention 1921*, (Nashville, TN: Marshall and Bruce Co., 1921), 45-50.

⁹³ Frank Tripp. “Hospitals Baptist.” *Encyclopedia of the Southern Baptists, Vol. 1*. 1958. 652.

⁹⁴ SBHLA, “Proposed Program Structure,” 4.

⁹⁵ The Missouri Baptist Convention and Baptist Memorial Health Care both used this tagline as a mission statement.

identity in the emulation of Christ's ministry, these hospitals had another peculiarly Baptist trait: a strong conception of separation between church and state.

While one should not consider their distinct wall between church and state affairs as an identity marker, this trend did play a distinct role in Baptist hospital history. Since the days when colonial Baptists experienced great persecution, Baptists have been reluctant to allow the government any room for influencing their affairs. This led many of the Baptist hospitals to reject federal funding. As the government became increasingly involved in funding health care through Medicare, the hospitals became increasingly hard-pressed to stay open. In the 1960s and early '70s, the Louisiana convention relinquished control of its four hospitals. They did so because of the high cost of health care and an unwillingness to receive federal funds.⁹⁶ The Arkansas convention released its hospital in Little Rock so that it could receive government subsidies. The hospital had begun to lose \$150,000 per year without Medicare reimbursements.⁹⁷ While some hospitals, such as Georgia Baptist Hospital,⁹⁸ did eventually receive aid, none did so without seriously considering weighing their beloved principle against other goals.

About the same time as the Baptist hospital "movement" began in earnest, Southern Baptists felt reverberations from the Social Gospel movement. The original Social Gospel can be traced at least popularly to the Northern preacher and intellectual Walter Rauschenbusch. Rauschenbusch influenced mainline Protestants in particular

Missouri Baptist General Association, "Minutes of the Missouri Baptist General Association 1958," (Jefferson City, MO: Missouri Baptist Convention, 1958), 59A.
Baptist Memorial Health Care, "Baptist Mission," About Us, accessed March 20 2015, <http://www.baptistonline.org/about/>.

⁹⁶ Carl A. Hudson, "Louisiana Hospitals," *Encyclopedia of Southern Baptists, Vol. 4*. (Nashville, TN: Broadman Press, 1986), 2322.

⁹⁷ Author unknown, "Arkansas -Baptists To Vote On Relinquishing Hospital," *Baptist Press*, Aug. 31, 1966, accessed Mar. 17, 2015, <http://media.sbhla.org.s3.amazonaws.com/2255,31-Aug-1966.pdf>.

⁹⁸ Frank Upchurch, *Hospital without Walls*, not published, 144.

around the turn of the century. He argued for a Christian renewal of society through institutional reform, but his message failed to acknowledge the need for personal redemption from sin. While Southern Baptists generally found his perspective of human nature to be untenable, they began to recognize the need for a full gospel that touched all of society. Young preachers who had graduated from Baptist seminaries brought a dualistic message emphasizing both personal salvation and societal renewal.⁹⁹ Glen Lee Greene, a leader at the Southern Baptist Hospital in New Orleans, noted a connection between the Social Gospel and the surge in Baptist hospitals,¹⁰⁰ and while the hospitals held dearly to their evangelistic mission, they certainly displayed a Southern adaptation of Rauschenbusch's message.

Beginning about 1910, the Baptist hospital ministry surged into existence. The Mississippi Baptist Convention opened its first hospital in 1911.¹⁰¹ In 1912, the Tennessee, Mississippi, and Arkansas conventions jointly opened Baptist Memorial Hospital.¹⁰² The Louisiana Convention gained control of a hospital in Alexandria just four years later.¹⁰³ By 1920, Baptists had founded 13 hospitals,¹⁰⁴ in 1930 they had 28,¹⁰⁵ and in 1954, they controlled 39.¹⁰⁶ With the movement growing so quickly (for its size), the Baptists did seek some affiliation.

⁹⁹ Paul Harvey, "Southern Baptists and the Social Gospel: White Religious Progressivism in the South, 1900-1925," *Fides Et Historia* 27, no. 2 (June 1, 1995): 59, 63-64.

¹⁰⁰ Glen Lee Greene, *The History of Southern Baptist Hospital*, (New Orleans: Southern Baptist Hospital, 1969), 15.

¹⁰¹ Robby Channell, email message to author, March 18, 2015.

¹⁰² Baptist Memorial Health Care Corporation, *A Century of Caring: a Legacy of Healing, Preaching, and Teaching*, (Memphis, TN: Baptist Memorial Health Care Corporation, 2012), 43.

¹⁰³ Hudson, "Louisiana Hospitals," 2322.

¹⁰⁴ Southern Baptist Convention, *Annual of the Southern Baptist Convention 1920*, (Nashville, TN: Marshall and Bruce Co., 1920), 66-67.

¹⁰⁵ 1930, 99.

¹⁰⁶ Frank Tripp, "Hospitals, Baptist," *Encyclopedia of the Southern Baptists, Vol. 1*, (Nashville, TN: Broadman Press, 1958), 652.

Although some leaders did propose collaborative structures, these never flourished with the robustness of the CHA. In 1915, a group gathered at the annual national convention to discuss a Southern Baptist Hospital Conference. Out of this discussion, they formed an organization comprising members representing each Baptist hospital. They hoped the group would foster closer ties between each of the hospitals as well as the SBC.¹⁰⁷ It appears that the SBC developed a separate organization, the Hospital Commission, formally establishing the committee at its 1924 annual meeting. The Hospital Commission would advise state hospitals in addition to operating the eventual institutions which the SBC might accrue.¹⁰⁸ It is unclear exactly what collaborative affect the Conference or Commission played in truly linking hospitals together, but whatever their impact, neither had the longevity of the CHA. The Catholic Hospital Association gained great lobbying authority with the federal government and American Hospital Association, and it played an important role both in standardization and later in mission retention; its influence remains strong today. Even in the height of the Baptist hospital movement, Baptist collaborative structures lacked a sufficient constituency to have the same influence as the CHA, and as states began to release their associated hospitals, collaboration fell by the way side.

Beginning in the 1960s, Baptist conventions began to release their hospitals primarily due to financial considerations. As noted earlier, the Louisiana convention discharged its hospitals due to their respective costs, the situation being exacerbated by

¹⁰⁷ SBC, *Annual of the Southern Baptist Convention 1918*, (Nashville, TN: Marshall and Bruce Co., 1918), 108-14.

¹⁰⁸ SBC, *Annual of the Southern Baptist Convention 1924*, (Nashville, TN: Marshall and Bruce Co., 1924), 73.

an unwillingness to receive federal aid.¹⁰⁹ Texas released its first hospital, Houston Baptist Memorial, upon the hospital's request. The hospital believed it needed broader community support to finance expansion programs, and it sought to add non-Baptists to its governing board, but the convention would not allow this while it maintained control of the hospital. The convention's resistance to federal aid probably played a role in this as well.¹¹⁰ Even the SBC released its two hospitals to a "Baptist-oriented Christian [institution] of mercy" in 1970.¹¹¹ State conventions in this era generally released their hospitals to private, self-perpetuating governing boards which still held tightly to Baptist commitments. Over the next three decades, Baptist conventions would release nearly all of their hospitals either to private boards or to secular hospital systems. Unfortunately, many of these left their Baptist commitments. As will be argued later in the paper, these hospitals lacked the rigid hierarchy of the Catholic Church which helped them to clearly define their institutions amid joining secular health systems.

In order to illustrate the typical trajectory of Baptist hospitals, this paper will examine three case studies. They show that by no means did all hospitals follow the same path, but indeed few of the hospitals retained their religious identity.

Missouri Baptist Hospital

¹⁰⁹ Hudson, "Louisiana Hospitals," 2322.

¹¹⁰ Author unknown, "Texas Baptists Reject Federal Aid; Release Two Institutions," *Baptist Press*. October 29, 1971, accessed March 6, 2015, <http://media.sbhla.org.s3.amazonaws.com/3275,29-Oct-1971.pdf>.

¹¹¹ Author Unknown, "SBC Executive Committee Proposes Hospital Divestiture," *Baptist Press*, February 17, 1970, accessed March 6, 2015, <http://media.sbhla.org.s3.amazonaws.com/2943,17-Feb-1970.pdf>

The Missouri Baptist Sanitarium began operation in 1887 under the direction of Dr. William Mayfield and his wife. Initially, Mayfield had opened up his home for patient visits and offered to lodge those who felt the need. Not long thereafter, Mayfield received authorization from the local Baptist ministers association to formally start a hospital. Being based largely on donation, the sanitarium struggled at first. The Mayfields never took a salary for their work. Due to some strife between Dr. Mayfield and A.D. Brown who chaired the board, Dr. Mayfield was asked to leave his position as superintendent which he did in 1896.¹¹²

During that same year, the sanitarium requested to be governed by the Missouri Baptist General Association, Missouri's state convention. The convention acquiesced, but the sanitarium continued to struggle financially. In 1900, a couple who had been working at the hospital for several years, the Calladwaters, proposed to the hospital that they take over leadership, Dr. Calladwater as physician in charge and Mrs. Calladwater as superintendent. Though the board initially declined the offer, in dire financial straits, they eventually accepted, making a decision which would turn out to be one of the wisest choices the board ever made. Under Mrs. Calladwater's leadership, the hospital thrived, making tremendous headway with the simple trick of gathering uncollected hospital bills in a business-like way. By 1902, the hospital had recovered reasonably sound financial footing.¹¹³ After her retirement in 1919 at age 69, Mrs. Calladwater received high praise for her tremendous effectiveness and hard work in a position for which she had no professional training.¹¹⁴

¹¹² Burnette, *One Hundred Years of Caring*, 5-21.

¹¹³ *Ibid.*, 30-35.

¹¹⁴ *Ibid.*, 55-56.

In the Great Depression, the hospital began fierce financial struggles. It had a surfeit of charity cases which far exceeded previous amounts, so the board was forced to limit these to twenty percent of the total volume. Posing an even greater challenge, the hospital sent out a great many bills which it could not collect.¹¹⁵ However, by the turn of the next decade, hospital admissions had risen to pre-depression levels.¹¹⁶ It continued to thrive, and as the 1940s closed, all outstanding debts had been retired. The hospital, standing more financially firm than ever before, began to look to building expansion.¹¹⁷

In 1952 as the hospital considered making new building plans, the board decided tentatively that it would not seek federal aid.¹¹⁸ As the hospital began in earnest in 1955 to consider building, a dilemma faced them squarely. As they attempted preliminarily to raise funds for renovations, their supporters demanded a move. The hospital neighborhood had become a slum, and paying customers felt both uncomfortable and cramped. In the end, the hospital decided to move its patient location to the west side of the city, a move the Board President Joyce Pillsbury determined to be within the will of God; though its location would change, its Baptist mission would not.¹¹⁹

In the 1960s, it appears the hospital remained explicitly Christian. In 1961 at the groundbreaking ceremony for the new hospital, Missouri Governor John Daulton gave an address in which he listed five reasons for a Baptist hospital. They included indigent care, carrying out Christ's healing ministry, the training of Christian nurses, enlargement of evangelistic endeavors, and creating a general Christian atmosphere.¹²⁰ The Governor's

¹¹⁵ Ibid, 80.

¹¹⁶ Ibid., 73, 92.

¹¹⁷ Ibid., 110.

¹¹⁸ Ibid., 112-13.

¹¹⁹ Ibid., 123-4.

¹²⁰ Ibid., 133-4.

statements are quite remarkable. He would have never been so earnestly Christian in his remarks if the hospital had not retained its mission. Indeed, although there had been some strife between the hospital and the Missouri Baptist Convention, the two remained connected. The 1960s, however, brought change in their relationship.

It was in this decade that the hospital likely became an independent institution. In 1960, the Convention withdrew financial support from the hospital on grounds that it was financially stable, actually posting a profit.¹²¹ The hospital board had not taken a similar proposition well in 1954, stating that “failure to support [the hospital] forfeits the right to dictate [our] policies.” Burnette moves on quickly in her records from this episode, but it gives a brief clue that the hospital-convention relationship had tensed.¹²² The Missouri Baptist Convention minutes still include an annual report in 1966, but the minutes give no explanation to their disappearance after that year, nor does Burnette or the Missouri Baptist newspaper make any mention of it. Never again does Burnette mention the Convention, so it is a reasonable conjecture that the relationship ceased in this decade. However, it appears the hospital still retained Baptist ideals for a number of years.

At least until 1987, the hospital leadership appears to have been generally Baptist. Burnette’s book offers the best insight. If the hospital had drifted from its Baptist moorings into a secularized, nominal form, one would expect a book celebrating its centennial anniversary to downplay the Baptist relevance for the day. However, this is not the case. The prologue, written by Board President Joyce Pillsbury, describes the work of the hospital as a “Christian ministry of healing.”¹²³ Pillsbury had been president

¹²¹ Author unknown, “Hospitals and the 1961 Cooperative Program.” *Word and Way* 97, no. 36 (Sept. 15, 1960): 5.

¹²² Burnette, *One Hundred Years of Caring*, 127.

¹²³ *Ibid.*, vii.

since 1955, and he had already demonstrated deep commitment to his Baptist identity.¹²⁴ Furthermore, Burnette devotes the book's three-paragraph epilogue exclusively to praising the hospital's heritage of sending out Christian missionaries, asserting that these are the best embodiment of the mission of the institution.¹²⁵ Whether the book represents the majority of opinion among employees or even leadership in 1987 cannot be deduced, but today, the hospital seems to be a different institution than when Burnette wrote.

Being currently a member of a non-Baptist, not-for-profit health system, Missouri Baptist Medical Center no longer clearly holds to its Baptist identity. In 1994, Missouri Baptist merged with the Barnes-Jewish Christian Health system, a group of not-for-profit hospitals which had recently formed in the St. Louis area to streamline business. The system in which Missouri Baptist merged had a centralized governance structure.¹²⁶ The hospital board ultimately made the decision to join BJC for financial reasons.¹²⁷ While the board of trustees for the hospital maintains fifty-one percent Baptist majority as stipulated in the merger, the hospital has changed a great deal since its hundredth anniversary, as least in the image it presents to the public.¹²⁸ The hospital website today makes no mention of Christ, a ministry of healing, or even a religious motivation. Sherry Blankenship, head of pastoral care at the hospital, stated that the hospital maintained its Baptist heritage through its culture of caring.¹²⁹ While the historic leadership of the hospital would certainly endorse this as a proper goal for a Christian hospital, they would

¹²⁴ Ibid., 126.

¹²⁵ Ibid., 147.

¹²⁶ Stephanie A. Chambliss, John O'Shaughnessy, Emily Rapp, and Peg Tichacek, "Before and After: a Snapshot of the St. Louis Healthcare Environment," Ed. Wayne M. Lerner, *Anatomy of a Merger: BC Health System*, (Chicago: Health Administration Press, 1997), 11-12.

¹²⁷ Ibid., 37

¹²⁸ Sherry Blankenship, interviewed by the author, March 20, 2015.

¹²⁹ Ibid.

not accept it as complete. Gone are the genuine Baptist commitments which the hospital once held.

Southern Baptist Hospital

From the start, founders of the institution treated Southern Baptist Hospital as a missionary endeavor. In 1920, the annual national convention had received a report detailing the great need which New Orleans had for a hospital and the great promise the city offered as a missionary enterprise. The report explained that the city, as a gateway to the South for foreign visitors and home to the nation's second most important port, offered a prime location for spreading the gospel both at home and abroad. Unless one included Baltimore, New Orleans housed more medical professionals and students than any other Southern city. The Protestants currently only had eighty hospital beds in the city, making it of strategic importance for the Baptists.¹³⁰ Clementine Morgan Kelly, a Baptist missionary to the city wrote in her plea for a hospital:

While on earth [Jesus] went about doing good and healing every manner of sickness and suffering. Through the healing touch He gained access to many a heart and home... May the lasting compelling fact enable our Baptist leaders to catch a vision of the deep need and wonderful opportunity before us for a Baptist hospital for New Orleans.¹³¹

Glen Lee Greene credits the publication of Kelly's article in which these words appeared with moving the Baptists to action.¹³² After careful deliberation, the Southern Baptist Convention opened the hospital for action in 1926.

¹³⁰ SBC, "Annual of the Southern Baptist Convention 1920," 69-70.

¹³¹ Greene, *The History of Southern Baptist Hospital*, 30.

¹³² *Ibid.*, 29-35.

In the original agreement, the SBC allotted an amount in its future budgets of \$2,000,000. It also required Louisiana Baptists to contribute \$100,000, and it asked the hospital board to raise \$400,000 in bond sales. While the SBC guaranteed this money for construction costs, it had only a nominal financial role in supporting the hospital thereafter. For instance, in 1932, the Convention granted about \$21,000, and the following year, it allocated just \$16,000.¹³³ Nonetheless, the hospital did quite well financially, posting average surpluses of \$32,500 for each of the first four years of operation. The hospital contributed an average of \$34,400 in charity care during the same period, a number not insignificant.¹³⁴

Though the hospital continued to thrive financially, their refusal to take federal funding certainly made financing large building projects difficult. In 1960, the hospital reported that it averaged filling its beds to 91 percent capacity, an ideal number for hospitals, but it struggled to raise enough capital for a building project it sought to undertake.¹³⁵ In 1962, it did finalize plans for a \$9,000,000 renovation.¹³⁶ However, with the initiation of Medicare in 1965, the hospital began to really suffer without federal subsidies. Not until 1969 did the hospital transition into the Medicaid program.¹³⁷ It was at this time that the Convention made a significant move.

¹³³ Southern Baptist Convention. *Annual of the Southern Baptist Convention 1933*, (Nashville, TN: Marshall and Bruce Co., 1933), 89.

¹³⁴ SBC, *Annual of the Southern Baptist Convention 1927*, (Nashville, TN: Marshall and Bruce Co., 1927), 110. ; SBC, *Annual of the Southern Baptist Convention 1928*, (Nashville, TN: Marshall and Bruce Co., 1928), 69. ; SBC, *Annual of the Southern Baptist Convention 1929*, (Nashville, TN: Marshall and Bruce Co., 1929), 58-62. ; SBC, *Annual of the Southern Baptist Convention 1930*, (Nashville, TN: Marshall and Bruce Co., 1930), 102.

¹³⁵ SBC, *Annual of the Southern Baptist Convention, 1960*, (Nashville, TN: Executive Committee, Southern Baptist Convention, 1960), 255-260.

¹³⁶ Greene, *The History of Southern Baptist Hospital*, 150-170.

¹³⁷ SBC. *Annual of the Southern Baptist Convention, 1970*. (Nashville, TN: Executive Committee, Southern Baptist Convention, 1970), 195.

In 1970, the Convention formally voted to release Southern Baptist Hospital. Baptist Hospitals Incorporated, a self-perpetuating board of directors, would privately own the hospital with 75 percent of the board required to be Southern Baptist. The SBC released its hospital for financial reasons. Because the leadership SBC could only approve long-term loans during its biannual meetings, the hospital had to postpone projects for inconveniently long periods of time. Additionally, the hospital's loans were the source of the majority of the SBC's debt.¹³⁸ Though they did not mention it in reports, the SBC likely wished to distance itself from an institution that now received federal aid. While the SBC still desired for the hospital to remain a Baptist institution, it seems beneath the Convention's pragmatic reasoning it no longer viewed the hospital ministry with the priority it once had.

Ultimately, Ocshner Health System, a secular hospital group, purchased the hospital, retaining the name Baptist but removing commitments behind the name. Until 1994, the majority of the board remained Baptist.¹³⁹ Interestingly enough, the hospital then merged for a brief moment with Mercy Hospital of New Orleans. However, in 1996, Tenet Health System purchased both hospitals. In 2006, the former Baptist hospital was sold again, this time to Ocshner. Though the physical hospital no longer continues in its Baptist identity, the Baptist board used funds from the sale to create a new organization, one which still carries on a similar mission.

With those funds, board members established Baptist Community Ministries, a privately-held grant-making foundation. This organization provides financial support to organizations in the New Orleans area which comport with its mission. "In response to

¹³⁸ Author unknown, "SBC Executive Committee Proposes Hospital Divestiture."

¹³⁹ Charles Beasley, interview by the author, February 2015.

the love of God revealed in Jesus Christ and in keeping with our Baptist heritage,” it seeks to care for the needs of people in a holistic fashion.¹⁴⁰ While this new incarnation of the hospital cannot fulfill the same functions of its predecessor, the mission statement reveals a high degree of continuity with the Baptist tradition. Does this count as successfully retained identity?

While the Southern Baptists did not truly succeed in retaining institutional identity through their hospital, they did demonstrate healthy adaptability. A significant portion of retaining institutional identity is simply keeping the institution afloat, and Baptists could not do both of these things for Southern Baptist Hospital. Readers should not be quick to blame the leadership. Having an insufficient number of like-minded hospitals to share services with, the hospital had little chance of surviving as a Baptist institution. It appears the self-perpetuating board had done a reasonably good job of retaining its identity up until 1996, or it would not have established an organization which closely modeled its Baptist heritage. If a lack of other like-minded hospitals to affiliate with was the bane of Southern Baptist Hospital, for a hospital in Memphis it continues to be a strength.

Baptist Memorial Hospital

Baptist Memorial Hospital in Memphis represents the brightest example of a Southern Baptist hospital collaborating with other hospitals to maintain its mission. In 1906, Dr. H.P. Hurt presented the idea for a community Baptist hospital during a picnic

¹⁴⁰ Baptist Community Ministries, “Mission,” Mission and Vision, accessed March 20, 2015, bcm.org/mission-vision.

for the local Baptist association. After Hurt preached a message on the Good Samaritan, he rallied the association behind his enthusiasm and was soon sent with a delegation of ministers from the Memphis area to present his idea to three state conventions. The Tennessee, Arkansas, and Mississippi conventions agreed to jointly govern the hospital by each supplying one third of the trustees. Six years later, the conventions opened Memorial Baptist Hospital, designating forty of its one hundred and fifty beds for charity care.¹⁴¹

Today, what was once a lone hospital has become a well-established hospital system with a strongly-Baptist identity. In 1914, the hospital nearly closed, having just ten of its thirty in-patients able to pay and having accumulated large debts.¹⁴² Today, the hospital thrives. Its mission is to carry out “the three-fold ministry of Christ – Healing, Preaching, and Teaching” by providing high-quality medical services.¹⁴³ The state conventions still appoint their allotted number of trustees, and the now health-system comprises fourteen hospitals within the three states. How has the system been so successful? Simply stated, it has succeeded because it is a system.

Baptist Memorial has succeeded more than any other Baptist hospital because it affiliated with a number of like-minded hospitals. Without other Baptist hospitals with which to affiliate, Southern Baptist hospitals have struggled to retain autonomy. Financial challenges forced even the Georgia Baptist Convention, which retained its flagship hospital until 1997, to sell its hospital to a secular organization. The Georgia convention

¹⁴¹ Baptist Memorial 43.

¹⁴² Memorial Baptist, 44.

¹⁴³ About Us, baptistonline.org/about/, Accessed March 20, 2015.

wisely removed its Baptist name from the hospital, thereby revoking its “bapticity.”¹⁴⁴ Other formerly Baptist hospitals still carry a Baptist name accompanied by only a vague remnant of their former identity. However, because of its location, Baptist Memorial had the ideal opportunity of forming a legitimate Baptist system of hospitals. Given the tremendous difficulty of negotiating institutional identity when a Baptist hospital joins a secular system, forming a Baptist system has proven a necessary step in retaining authentic identity. With this in mind, then, one can draw some conclusions.

Baptist Hospitals: Some Conclusions

Beginning in the 1960s, most Baptist conventions released control over their hospitals in favor of giving authority to independent local boards of directors, and these decisions were typically made for a couple of reasons. First the state conventions, following the Baptist model of church-state separation, hesitated to accept federal aid. With the rise of government subsidy through Medicare and Medicaid, such a position became financially untenable. Independent boards, no longer appointed by the conventions or financially supported by them, were free to accept such aid. Second, the state conventions did not stand resolute in their commitment to hospital ministry, so they were more inclined to give up control to boards. While a few significant individuals fought vehemently for a unified Baptist hospital program, the individuals who gave most sacrificially for Baptist hospitals were committed to their local hospital. Those who sacrificed did so for their hospital, not for the state program. In this, the Baptist exhibited

¹⁴⁴ Author unknown, “Permission Granted to Sell Medical Center,” *The Christian Index*, December 19, 1996, 8.

their affinity for autonomy. Such a focus resulted in autonomous Baptist hospitals which could retain their identity as individual institutions but struggled to form affiliations with other hospitals. The new pressure of the 1980s to form health systems pushed Baptist hospitals in two directions: for health systems with other Baptist institutions or eventually merge with other non-Baptist hospitals.

Those Baptist institutions which formed hospital systems under the authority of their respective Baptist conventions had the greatest success at maintaining their Baptist heritage. Mississippi's Baptist Health System and Baptist Memorial Health System, remained under the governing authority of a convention, and this solution gave them the greatest chance to keep their mission. The conventions and their appointed representatives had (and still have) a strong incentive to keep their hospitals close because these institutions represent the convention. When Baptist hospitals can form systems of their own and preserve connection with their conventions, they have a much higher probability of retaining their identity. Admittedly, Baptist hospital systems still may maintain their religious identity to a degree apart from sponsoring conventions. Kentucky Baptist Health System, which broke ties with its state convention a number of years ago, still retains at least a form of its mission, stating it desires to "live out its Christ-centered mission."¹⁴⁵ Baptist Health of South Florida, though having only been sponsored by a local Baptist association, expresses an even clearer Christ-centered commitment.¹⁴⁶ However, nowhere does this hospital's website reference its historic Baptist heritage. Baptist systems which have remained tied to their convention have

¹⁴⁵ Baptist Health, "About Baptist Health," accessed March 20, 2015, <https://www.baptisthealthkentucky.com/corporate/about-baptist-health/index.html>.

¹⁴⁶ Baptist Health South Florida, "Our Mission," Fulfilling Our Mission, accessed March 20, 2015, <https://baptisthealth.net/en/about-baptist-health/pages/fulfilling-our-mission.aspx>

stayed most faithful to their mission. Hospitals which broke from their convention have fared differently.

Though in the past, autonomous Baptist hospitals managed to retain their mission, they lost their strong religious identity when financial challenges drove them to join secular health networks. While the Missouri and New Orleans hospitals remained independent, their self-perpetuating boards tethered them to Baptist identity. However, the evolving hospital climate forced them to seek affiliations, a move which cost them their identity. Today the hospitals are Baptist in name, but their mission bears the mark of a community hospital, not an authentically Baptist institution. To the credit of some hospitals, when they no longer had the option of keeping their identity, they evolved their ministry. The Baptist board in New Orleans used its funds to adapt its ministry, and the Georgia Baptist Convention eventually did the same. This, however, represents only a limited degree of success. In general, Baptist hospitals that have not formed Baptist hospital affiliations and remained tied to their conventions have not remained missionally faithful.

Comparing the Two

Catholic hospitals have generally been more successful at retaining their religious identity than the Baptist institutions for three reasons. Most obviously, Catholic hospitals have existed in greater numbers, making it far easier for them to affiliate with each other. As noted earlier, Catholic systems represent three of the six largest non-profit systems in

the US, and a fourth system, Dignity Health, contains primarily Catholic hospitals.¹⁴⁷ In 1922, during the heat of the Baptist hospital movement, Baptists bemoaned that fact “that though the Catholics are smallest in numbers, they have nearly three times as many hospitals as all the evangelical denominations combined...”¹⁴⁸ Indeed the Catholic onslaught probably served as an impetus for further Baptist hospital construction. Women religious established Catholic hospitals relentlessly during the decades bookending the turn of the twentieth century. Having so many hospitals has enabled these institutions to form Catholic affiliations with relative ease, and being joined with like-minded hospitals, all involved have had a far easier time at keeping their identity than hospitals which joined secular systems. The numerical magnitude of Catholic hospitals underscores the remarkable earnestness of the founders of these hospitals: Catholic sisters.

Second, as the Baptist conventions waned in commitment to their hospital ministries, the sisters continued steadfastly in enterprise. Generally speaking, while some a couple Baptists conventions continued to support a hospital ministry through oversight, most allocated their leadership solely to local leaders. In contrast, women religious made health care ministry a more central part of their social mission. As their membership declined, the remaining sisters exerted a disproportionately large influence, and they vigorously worked to pass on their mission to a laity which was becoming increasingly involved in Catholic hospital ministry. While a very few Baptist conventions continue their leadership within hospital ministry into the present, most have preferred to give their individual hospitals autonomy for a variety of reasons. While each had good reasons for

¹⁴⁷ Molly Gamble, “15 Largest Nonprofit Health Systems | 2014,” *Becker’s Hospital Review*, June 23, 2014. <http://www.beckershospitalreview.com/lists/30-largest-nonprofit-health-systems-2014.html>

¹⁴⁸ SBC. *Annual of the Southern Baptist Convention 1922*, (Nashville, TN: Marshall and Bruce Co., 1922), 87.

releasing their institutions, the fact that some conventions still support hospitals demonstrates that most conventions could have continued in support had they been really inclined. Their relinquishing of leadership highlights another distinctive reason for a greater Catholic success.

Third, Catholic hospitals continue to submit to an authority structure which clearly delineates between Catholic and non-Catholic hospitals, while many Baptist hospitals today retain only the shell of their religious name.

The local bishop exercises the negative power to divest a hospital of its Catholicity. For example, in 2010 the local bishop revoked the catholicity of St. Joseph's Hospital in Phoenix after the bishop deemed the hospital to have violated the ERD.¹⁴⁹ The hospital's mission statement today states that it is committed to furthering the healing ministry of Jesus," but nowhere does it call itself a Catholic hospital.¹⁵⁰ The bishop also exercises positive authority to negotiate catholicity even in a hospital like Mercy Pittsburgh which is owned by a secular system. This authority is crucial for hospitals which are affiliating with non-Catholic organizations because it clearly defines the identity of a hospital to the public. Ultimately, the bishop concerns himself with defending the mission of the Catholic Church, but in doing so, he helps the hospital to remain faithful to its Catholic identity by clearly defining what Catholic identity is. Autonomous Baptist hospitals struggled to do this.

¹⁴⁹ Catholic News Agency, "Phoenix Bishop: Hospital Remains Non-Catholic, Despite Collaboration With a Catholic University," *National Catholic Register*, July 24, 2012, accessed March 20, 2015, <http://www.ncregister.com/daily-news/phoenix-bishop-hospital-remains-non-catholic-despite-collaboration-with-cat/>

¹⁵⁰ Dignity Health: St. Joseph's Hospital and Medical Center, "St. Joseph's Mission, Vision and Values," About Us, accessed March 21, 2015, <http://www.dignityhealth.org/stjosephs/about-us/mission-vision-and-values>.

The autonomy of Baptist hospitals made it permissible for private institutions apart from convention sanctioning to still be “Baptist.” The institutions had a diminished concern for how their institution reflected their convention’s mission. While the hospitals remained autonomous Baptist institutions, not yet joined with secular hospital systems, they continued to reflect their Baptist heritage. However, when they joined secular organizations, they opened themselves up to compromise. It is one thing for an organization to abruptly sell its hospital, breaking all ties and pretensions of reflecting its original roots. The Georgia convention operated with this mentality, and the Atlanta Medical Center today bears no sign of compromise; it is a thoroughly different institution. However, the Missouri Baptist Medical Center, while clinging to its Baptist name, gives a false impression of the mission of Missouri Baptists. Autonomy makes holding a uniform front of identity across multiple organizations nigh impossible.

Baptist Memorial has most successfully maintained its Baptist identity both because it has stayed connected to its parent conventions and because it has formed a successful Baptist hospital system across three states. Had the original Baptist Memorial hospital been unable to affiliate with other hospitals, it would most likely been forced to join with a non-Baptist hospital system. In this case, one cannot be certain whether or not the state convention’s sponsorship would have sufficiently anchored the hospital to its Baptist identity. Baptist conventions have not demonstrated historically that they are committed to hospital ministry the way the Catholic Church is. These conventions may be an anomaly in this respect; perhaps they are committed wholesale to their hospitals. In this case, they could clearly negotiate with the secular organizations to insure their hospitals kept their Baptist mission. Baptist Memorial stands as the best example of

fidelity to the original Baptist mission, but unfortunately, it is an anomaly among Southern Baptist Hospitals.

Conclusion

While Southern Baptists should be commended for the duration of time which they maintained their identities – some for near a century, Catholics have generally done a better job at maintaining their specifically Catholic mission. Through their dedication and the blessing of God, women religious and their local communities devoted more of their resources to founding and maintaining their hospitals. While Baptists did develop a number of hospitals, their numbers scarcely compared to the number of Catholic institutions. With these large numbers, Catholic hospitals have been able to form the health systems which they need to steadfastly maintain their mission, while Baptist hospitals have only two real systems which truly reflect their Baptist heritage. Even when they have joined with secular hospitals, a significant number of Catholic hospitals have displayed fidelity to their mission. The local bishop has required that the hospital submit to the ERD and other more general marks of catholicity, and if not, he has revoked their privilege as a Catholic institution. Today, no Baptist hospital as a member of a secular system continues in its Baptist heritage. Baptist Memorial and Baptist Health System, still tied to their state conventions, represent the best of Southern Baptist Hospitals.

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Appendix: Integration

Part I: What Does Identity *Really* Matter Anyway?

This paper is designed to investigate mission and identity in technical sense, and thus, it is more focused on leadership and theory than grassroots and practical results. However, it is worth considering why identity even matters: how individuals are influenced by the hospital? The real impact of a hospital can be measured by investigating the opinions of the employees, patients, and the general public. Each would have a valuable perspective. This could be studied through surveys and polling of each of the groups, research which is far beyond the purview of this paper. Based purely upon speculation, though, the author believes that the practical differences experienced by most patients would be minimal.

At modern Southern Baptist or Catholic hospitals, only those individuals who inquired deeply would find a significant difference. Doctrinal distinctions which so clearly divide Southern Baptists and Catholics cease to be as noticeable for hospitals. Nurses do not question their patients over the definition of justification. Apart from a differing opinion on the ethics of artificial contraception, Baptists and Catholics do not differ a great deal in the way they daily care for patients. Both strive for steadfast, compassionate care with which they seek to manifest the love of Christ. In decades past, Southern Baptist health care evangelized more overtly than Catholics, but today, this seems to have lessened. The religiously-motivated differences which an average patient might experience in a two-night stay at either hospital would probably be very minor. Only patients who desired to actually understand about the denomination associated with

the hospital would truly discover the difference. Modern American religious hospitals have little value for actual proselytizing. They function as a tool for making men ask questions. Only then would the average patient discover the true identity of a Catholic or Baptist hospital.

Part II: Applying Accountability to Local Churches and Religious Schools

All ideologically-motivated organizations – that is to say, *all* organizations – must struggle with identity retention at some level. Religious organizations in an increasingly secular America must wrestle arduously with the issue. Based on the narrative presented above, the Catholic hierarchy has contributed significantly to the success Catholic hospitals can boast in identity retention. Baptist autonomy did not fail until their hospitals were forced to join with non-Baptist hospitals. Can these findings be applied to other sorts of religious organizations? First, the author will compare the hospitals with local churches, highlighting a couple of distinctions between the two. Then, it will make another comparison between hospitals and religious universities. Based on the two distinctions between hospitals and local churches, one cannot fairly apply the same principles of identity retention uncovered in this paper to local churches. However, one can more aptly compare hospitals and colleges. The author will conclude by suggesting the potential benefits for a hierarchical connections between a denomination and religious school.

A religious hospital and a local church differ first because of their purpose. God charged the local church to make disciples, and a major component of that is teaching

specific theological truths grounded in Scripture. The local church finds unity with the larger denomination through its interpretation of Scripture. It might gradually drift away from its denominational identity if it fails to make clear its doctrinal commitments, but generally, churches make intentional decisions to change their doctrinal statements. Indeed, the most obvious example is during the Reformation century when dozens of new Christian denominations formed. This fragmentation was hardly drifting; these groups intentionally changed their theological commitments. Hospitals, on the other hand, have a propensity to drift.

Hospitals can drift from their denomination more easily than local churches because they do not have the rigid set of doctrines; nonetheless their identities are rooted in these doctrines. The Church applies its doctrines through its appendage ministries, hospitals being one form of this. While a religious hospital does not have a doctrinal statement, the components of its identity result directly from doctrine. The Catholic theology of the incarnation of Christ and the resulting sacramental living of a believer yields compassionate care. Apart from this theology, a Catholic hospital is simply a place with nice people. These truth-claims are not an obvious part of a given hospital's identity. For instance, when this author explained Catholic hospital identity, he did not say "see Council of Trent." Hospitals need the Church to make sense of their actions. Such an explanation requires more than a hospital setting can facilitate. On a practical level, a hospital chaplain could explain the full doctrine of the incarnation to a dying patient who wanders why the staff provides such exceptional care. However, without a full explanation of Christ, even the incarnation does not make sense. Unless they stay connection to the Church, hospital identity cannot stand under its own weight. A hospital

exists to plant seeds. It is the Church's responsibility to root the hospital. Not only does the local church differ in its purpose, but it also differs in its means of funding.

The local church receives funding through donations. While church leadership must steward its resources well, they depend upon the Spirit of God working to make His people generous. While some churches revert to fundraising through the latest marketing strategies, biblical churches rely on God to sustain them financially. Because they obviously depend upon the movement of God for their existence, they are not as likely to revert to a consumerism model in which they must appease the crowds to continue succeed financially. (Certainly this takes place, but it is in no way biblical). If God does not provide sufficiently to support His church, apparently He does not desire it to continue in its present form. However, the hospital exhibits a quite different funding model.

The religious hospital sustains itself, existing primarily through revenue. Sponsoring denominations donate very little to religious hospitals, which by nature are a business. The goal of every business is to sustain itself and to expand. The challenges of the modern hospital environment tempt leadership to compromise their identity for the sake of survival. Suppose a hospital aims to serve the needy with compassion in the name of Jesus, but it cannot survive financially on its own. The only options are to file for bankruptcy and terminate operations, or to merge with another larger hospital group. This group will allow the hospital to provide healthcare if it diminishes its "religious rhetoric." The administrator might be very inclined to join with the secular system and mar its mission in the process. Surely a few people could still be touched for Christ through the endeavor. The point is not to determine which choice is better, but rather to highlight how

hospitals must be sensitive to the market. The fact that they do not have a set of obvious doctrinal commitments only exacerbates their plight. Both of these factors reveal that the local church can more easily retain its identity than a hospital can. However, this cannot necessarily be said for a religious college.

While religious colleges typically have more comprehensive tenets of faith, they struggle with the same economic pressures of religious hospitals. Religious schools typically try to make clear their theological positions, although these range narrowness and specificity. Because of this, their leadership can more easily associate the importance of their doctrines with their identity and actions. As a result, the leadership is less likely to make pragmatic decisions and accidentally violate their theological foundation. They might intentionally shift their doctrines, but they are far less likely to accidentally drift than hospitals. The danger: financial considerations might cause mission drift. Colleges function as businesses just like hospitals. While they do not face the challenges of merger, they still experience consumer pressures to broaden their scope or change their image. They share a definite similarity with religious hospitals in this respect, a similarity which could also cause them to drift. For a couple reasons, then, religious universities might benefit from a close connection with church denomination for sake of identity retention.

A tight connection between a denomination and a college might help the school hold fast to its identity. First, such a linkage might help the college to look past its financial needs to the deeper duty of theological fidelity. Second, the denomination could more forcibly pressure the college if need be to restore its identity. This would require a more hierarchical connection in which the denomination had some authority to pressure

the school. To suggest this, one implies that the denomination would by default be interpreting Scripture correctly. Scripture does not make some issues as clear as others, nor does it make all issues equally central. Some questions which a denomination ought to take a clear stance on may not be as essential for a university to definitively answer. Let each school decide what it desires its identity to be. However, a school which anchors its identity in a denomination can more easily weather economic pressures than one which is tethered to only its own anchor.

Local churches are naturally connected to their own denomination through their doctrinal commitments. If they shift from their moorings, they do so willfully. Hospitals do not carry such an obvious set of theological positions, and in the face of economic pressure, they may more easily forget the importance of their denomination's dogma to their religious identity. Denominational universities form something of a middle way. While they have a more clearly-explicated set of beliefs, they also experience financial hurdles which might persuade them to drift in order to satisfy consumer demands. More than a few schools have floated this route, and educational institutions are perhaps more prone to progressivism than any other sort of group. It is a hard work to retain identity, a work which requires accountability, whether internal or external. All religiously motivated organizations would do wisely to place checks in their path. Mission drift is real.