Daughters of Charity: Women, Religious Mission, and Hospital Care in Los Angeles, 1856-1927

Kristine Ashton Gunnell

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A captivating story, culled from extensive historical research, documents how ingenuity, determination, and faith enabled mission-driven Daughters of Charity to establish, develop, and provide healthcare in Los Angeles. This work contains multiple examples of their flexibility to overcome barriers of culture, religion, language, and scarce resources in the context of frontier politics but without compromise of their faith-based mission of service to persons in need. I highly recommend this work of scholarship which makes understandable how Catholic sisters created a health center on the frontier in a rented adobe without running water, and transformed the city into a medical center, a monument of charity in the city of Los Angeles.

Betty Ann McNeil, D.C., Scholar-in-Residence
DePaul University, Chicago, IL

Kristine Ashton Gunnell, Ph.D., is a Research Scholar at the UCLA Center for the Study of Women. She specializes in the histories of gender and religion in the American West.
DAUGHTERS OF CHARITY

Women, Religious Mission, and Hospital Care in Los Angeles, 1856-1927
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Kristine Ashton Gunnell, PH.D.
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Abbreviations

AALA Archival Center of the Archdiocese of Los Angeles, Los Angeles, California
HM Honnold-Mudd Library Special Collections, Claremont, California
LABCS Executive Office of the Los Angeles County Board of Supervisors, Los Angeles, California
SVMCHC St. Vincent Medical Center Historical Conservancy, Los Angeles, California
Seaver Center Seaver Center for Western History Research, Natural History Museum of Los Angeles County, Los Angeles, California
UCLA Special Collections, Young Research Library, University of California Los Angeles, Los Angeles, California
Thank you to past Visitatrix Margaret Keaveney, D.C., and the provincial council, who initially granted permission for me to research in the sisters’ archives, and to Visitatrix Marjory Ann Baez, D.C., and her council, who continued to support the project. Thank you to Cora Grassmann, Liz Sandoval, Mimi Smith, and others at the foundation office for their constant encouragement and support. Thank you as well to the Ladies of Charity, St. Vincent Medical Center Historical Conservancy, and the DeAndreis-Rosati Memorial Archives for providing opportunities to discuss my work. I would also be sorely amiss if I did not thank Ken McGuire, the former archivist at St. Vincent Medical Center Historical Conservancy. Ken immediately embraced the project, and his knowledge of the sisters’ institutions and their organizational culture allowed him to make the necessary connections that would secure its ongoing support. Reflecting the Vincentian values of compassionate service and inventiveness to infinity, Ken went out of his way to help me to find necessary resources inside and outside of the institution, and he kindly introduced me to people who could help me to further the project. He willingly shared his extensive knowledge and time to help me to understand the sisters’ history and the spirit of their mission, and he never ceased to surprise me by pulling out interesting material that helped me to fit the pieces together. Joan Gibson, D.C., the conservancy’s current archivist, also helped me to tie the loose ends together, providing access so I could double-check materials, gather images, and get all the little things done that I needed to move towards publication.

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On 6 January 1856, six Daughters of Charity arrived in the Plaza in Los Angeles. Invited by Bishop Thaddeus Amat, C.M., the sisters intended to establish an orphanage and school in the pueblo. Poverty, accident, and disease deprived many children of their parents, and the orphans needed to be housed, clothed, and educated. In addition, frontier isolation had left many other Catholic children unfamiliar with the fundamentals of their faith, and the Daughters of Charity sought to rectify this situation. Angelenos later induced the sisters to also open a hospital, known as the Los Angeles Infirmary, to care for the county’s indigent patients. Both facilities served immigrants and residents alike, and the sisters accepted all those in need, regardless of race or creed. However, this was not an easy stance to take in a city that struggled with racial and class divisions, periodic economic downturns, and shifting configurations of political power. The Daughters of Charity negotiated this uneven terrain as they sought to maintain their institutions without compromising their religious community’s spiritual values.

In Daughters of Charity: Women, Religious Mission, and Hospital Care in Los Angeles, 1856-1927, I argue that the Daughters played an instrumental role in the development of hospital care in the American West. In 1858, these Roman Catholic sisters established the first institutionalized healthcare services in Los Angeles, and in 1869, they were the first women to incorporate a business in the city. The sisters provided food, housing, and nursing care for the sick poor, first through government subsidies and later by allocating a portion of private patients’ fees to charity work. I argue that their community’s philosophy of ethnic and religious inclusion positioned the Daughters of Charity as intermediaries between individuals from different cultures and classes as they sought to fulfill their religious mission to serve the sick poor. To do so, however, the Daughters had to adapt to rapidly changing conditions in the medical marketplace in the late nineteenth and early twentieth centuries. The growing importance of surgery, the introduction of new technology, and the advent of structured nursing school programs changed
the relationships between hospitals, doctors, nurses, and patients. People of all classes started to seek hospital care, and the Daughters had to adjust their services accordingly. In the early twentieth century, the sisters constructed new buildings, bought new equipment, and expanded the nursing staff. The Daughters of Charity retained their historic position as leaders in hospital care in Los Angeles, and despite shifting financial structures that affected the industry as a whole, the sisters continued to provide a significant amount of care for people living in poverty.

Importantly, the Daughters of Charity engaged in strategies that both promoted the vitality of the institution and maintained their community’s commitment to care for the indigent sick. The most important of these strategies included securing public funding in the 1860s, contracting with newly-established railroad insurance programs in the 1890s, and developing nursing education in the early twentieth century. These strategies are representative of emerging trends within the medical marketplace, but the key to understanding the sisters’ work is examining the connections between nursing practices, financial security, and their community’s spiritual goals.

In the last decade, a scholarly interest has re-emerged in the influence of “vowed women” (to use Sioban Nelson’s term) in American history, including members of active religious communities like the Daughters of Charity. Nelson and Barbra Mann Wall write about Catholic nursing communities, while Maureen Fitzgerald, Dorothy Brown, and Elizabeth McKeown explore the influence of Irish Catholic nuns on social welfare practices in New York City. Bernadette McCauley also argues that Catholic sisters’ focus on “community, service, and spirituality” provided an alternative model for the development of institutional health care in New York.1 While a few scholars discuss the experiences of Catholic sisters in the nineteenth-century American West, the interactions of gender, religion, and culture in this region deserve further evaluation. Building on the work of Michael E. Engh, S.J., Anne M. Butler, and others, my research 0./analyzes the social, political, and economic relationships cultivated by the Daughters of Charity to establish and maintain charitable institutions that served poor persons in Los Angeles.2

The Daughters of Charity were among the first to engage in Catholic charitable endeavors on the Pacific Coast, and they adjusted their services to meet the needs of the communities in which they served. At the invitation of the newly-appointed bishops in California, the community established orphanages in San Francisco in 1852, Los Angeles in 1856, and Santa Barbara in 1858.3 By 1861, the sisters in Los Angeles expanded their charitable works to include an orphanage, a hospital, and a seminary (or novitiate) to train new recruits. At this time, the Los Angeles Infirmary represented only one facet of a cohesive social service program provided by the Daughters. As such, the sisters approached their hospital ministry as a means to serve impoverished individuals, rather than as a vehicle for the professionalization of medicine. Until 5 September 1873, both the hospital and the orphanage remained under the leadership of Sister Mary Scholastica Logsdon, D.C., who served as administrator of the Los Angeles Charitable Institute. As the institutions grew, the sisters’ superiors in Emmitsburg, Maryland, decided to divide them into separate houses, thus allowing the sisters in charge to concentrate more fully on the organization’s specific needs.4 By the

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1870s, the hospital and orphanage had different institutional trajectories. The orphanage, incorporated as the Los Angeles Orphan Asylum in 1869, continued to function as a social welfare institution, but when scientific medicine encroached on the social welfare functions of the Los Angeles Infirmary, the Daughters of Charity adjusted their focus and embarked on the modernization process. By 1902, the hospital operated as a medical enterprise founded on a religious mission.

Most scholarly studies of Catholic healthcare in the United States focus on eastern urban areas, and consequently, the history of Catholic contributions to hospital care in the west remains underdeveloped. Christopher Kauffmann, Barbra Mann Wall, and Edna Marie Leroux, R.S.M, all touch on Catholic sisters’ nursing activities in the region, but more work needs to be done before scholars thoroughly understand the implications and challenges of frontier conditions for religious communities, as well as Catholic sisters’ interactions with the Church.

By studying a single religious community, my research provides the specificity necessary to explore the ways that Catholic sisters engaged with the many different players who sought to control the development of healthcare in the western United States. In Los Angeles, the Daughters collaborated with government officials and cooperated with physicians, but the sisters consistently constructed (and fiercely protected) an autonomous space in which they could implement their spiritual values of simplicity, humility, charity, and service to those living in poverty. While my work contributes to the history of religion and healthcare in the west, it also adds to our understanding of the history of the Daughters of Charity. To date, much of the literature about this religious community in the United States has focused upon the life of Elizabeth Ann Bayley Seton and the activities of her early counterparts. However, there are a few works that have a broader scope. Daniel Hannefin, D.C., wrote a national survey about the community in 1989, Ellin Kelly finished her two-volume compilation of excerpted letters in 1996, and more recently, Betty McNeil, D.C., and Martha Libster published Enlightened Charity, which explored the community’s holistic approach to healthcare in the mid-nineteenth century. Sisters serving in the Province of the West have also compiled institutional histories over the years, including a recent effort to edit and publish selected letters from the pioneer sisters in California, but much more can (and needs to) be done to illuminate the historical significance of the sisters’ activities in Los Angeles. Michael E. Engh and Monsignor Francis J. Weber include chapters on the Daughters in their work on Los Angeles, and Anne M. Butler has written an essay about the sisters’ activities in Virginia City, but this book is the first in-depth


study of the Daughters of Charity and their hospital work in southern California.\(^7\)

The story of the Daughters of Charity in Los Angeles fits within the larger framework of migration and westward expansion in the United States, as well as the expansion of the American community itself during the nineteenth century. While Seton patterned the Sisters of Charity of St. Joseph’s after the Daughters of Charity, her successors negotiated a formal union with the Paris-based community in 1850.\(^8\) The move was primarily intended to secure the American community’s continued viability by placing it in the charge of the Congregation of the Mission, insulating the sisters from internal interference and the direct governance of American bishops, as well as strengthening the community’s male advocacy within the church. The union also connected the American sisters to a rapidly expanding religious community whose reach extended from Europe to Latin America by the end of the century.\(^9\) In part, the sisters’ missions in California reflect the transnational mindset of the Vincentian leadership at the time, intent on extending religious education, healthcare, and social services among poor persons to what was then considered the edges of the earth.

As a whole, Catholic sisters have had a tremendous impact on the development of American healthcare. In 1930, Catholic sisters from 154 different religious communities controlled 12.7 percent of all nongovernment sponsored hospitals in the United States, and 60.7 percent of religious hospitals. With a total capacity of 85,803 beds, Catholic sisters and the nurses they trained cared for hundreds of thousands of patients each year.\(^10\) For many, Catholic sisters became the face of hospital care in the United States. Likewise, Catholic sisters shaped the experience of generations of lay nurses. Of the 641 Catholic hospitals surveyed


\(^8\) Although several of its Sulpician superiors favored uniting the Sisters of Charity of St. Joseph’s with the Daughters of Charity from the beginning, the plan was deemed untenable by 1812. The American community was inspired by Saint Vincent’s and Saint Louise’s teachings and shared nearly all of the French community’s Common Rules, but no additional efforts were made to formally unite the two groups until the 1840s. Although the sisters had no official ties with the Society of Saint-Sulpice in France, the superior of the American Sulpicians and superior of St. Mary’s Seminary seminary in Baltimore continued to be the ecclesiastical Protector of the Constitutions of the Sisters of Charity and also provided a priest to be the superior general (or director) of the Sisters of Charity of St. Joseph’s, according to the agreement approved by John Mary Tessier, S.S. (superior of St. Mary’s Seminary, 1810-1829) and Archbishop John Carroll in 1812. Although Antoine Garnier, S.S. (superior general of the Society of Saint-Sulpice, 1827-1845) had encouraged the American Sulpicians to relinquish any commitments other than the education of priests in the late 1820s, his successor Louis de Courson (superior general, 1845-1850) ordered these men to exclusively concentrate on their primary mission. Diverting communities of religious women stood outside this objective, and Louis R. Deluol, S.S. (superior general of the Sisters of Charity, 1826-1830, 1841-1849) started to seriously investigate the potential of unifying the American sisters with those in France as a means to both relieve the Sulpicians of this responsibility and to provide additional stability for Sisters of Charity of St. Joseph’s. As part of the centralization process that reinforced ecclesiastical authority in the mid-nineteenth century, several American bishops sought greater control over religious communities in their dioceses. Conflicts between sisters and bishops regarding their rules, leadership, institutions, and most importantly, their community’s autonomy were common. Some bishops encouraged sisters to separate from their communities and form a diocesan congregation. The latter remained under the bishop’s jurisdiction, while pontifical orders (communities with papally-approved constitutions like the Daughters of Charity) did not. As a result of a policy dispute with the Emitsburg council regarding the care of orphaned boys, Bishop John Hughes organized a diocesan community called the Sisters of Charity of New York in 1846, causing considerable disruption and unease among the sisters involved. The Congregation of the Mission acted as superiors for the Daughters of Charity, and Deluol hoped that placing the Sisters of Charity of St. Joseph’s under their direction would provide strong local and international advocates for these women within the church, potentially avoiding future conflicts with bishops. In addition, spiritual direction from members of the Congregation of the Mission could assure the preservation and integrity of the community’s Vincentian spirit.

\(^9\) The Daughters of Charity expanded from France into Poland in the seventeenth century, and established missions in Spain, Italy, Russia, and Lithuania in the eighteenth. They also expanded into Mexico in 1844 and sent sisters to China in 1852. See Vicente De Dios, C.M., Historia de la Familia Vincentina en Mexico, 1844-1994, 2 vols. (Salamanca, Spain: Editorial CEME, 1993); Susan E. Dinan, Women and Poor Relief in Seventeenth-Century France: The Early History of the Daughters of Charity (Aldershot, England; Burlington, VT: Ashgate, 2006), 143; Hannefyn, Daughters of the Church, 216.

in 1930, 429 conducted schools of nursing. Catholic sisters trained nearly a third of all student nurses in the United States. Of these, the Daughters of Charity managed fifty-six schools of nursing with an enrollment of 3,532 students. Training schools not only allowed Catholic hospitals to economically expand their labor force, but they also perpetuated the spiritual side of nursing care.

Although most Catholic hospitals remained concentrated in the northeast, the Daughters of Charity participated in the expansion of hospitals in the American West. Many of the sisters’ orphanages maintained infirmaries, and the Daughters opened the Los Angeles Infirmary (now St. Vincent Medical Center) in 1858, St. Mary Louise’s Hospital in Virginia City in 1875, the San Jose Sanitarium and Home (now O’Connor Hospital) in 1889, and Mary’s Help Hospital in San Francisco in 1912 (now Seton Medical Center in Daly City). In 1892, they opened Hotel Dieu in El Paso, Texas. The sisters opened other hospitals in Dallas, Austin, Sherman, and Waco, Texas, between 1898 and 1904. In the west, sisters encountered individuals from diverse cultures and classes, and they negotiated language barriers, racial and religious bigotry, and in the early days, rough physical conditions. In Los Angeles, the Daughters of Charity welcomed native-born Californians and Mexicans into the sisterhood during the nineteenth century, although by 1920, most of the sisters were the daughters of Irish and German immigrants. Nevertheless, they sought to extend their religious community’s philosophy of respect for impoverished individuals regardless of race or creed wherever they served. The sisters shaped the direction of healthcare in the American West, and in part, served to ameliorate the race, class, and religious divisions that plagued the region.

This book consists of six chapters which trace the development of the sisters’ hospital from its frontier beginnings to its full embrace of “modern” scientific medicine symbolized by the opening of the new St. Vincent’s Hospital on Alvarado Street in 1927. My methodology relies on rigorous textual analysis of archival material, particularly personal accounts, corporate records, and maps. The study is primarily qualitative, but I incorporate some quantitative analysis drawn from the hospital’s admission records. Since the Daughters of Charity interacted extensively with both the English-speaking and Spanish-speaking populations of Los Angeles, I also include archival material in both languages. One note on terminology: unless otherwise identified, all Catholic sisters discussed in the book are Daughters of Charity. I have omitted the abbreviation “D.C.” after a sister’s name in the remaining chapters. Because the title “Sister” acted as an important part of these women’s personal identities, I have chosen to represent them as they referred to themselves, using “Sister Scholastica” rather than the more recent practice of referring to women by their last names.

Chapters one through four examine the Los Angeles Infirmary and its role in the “Americanization” of Los Angeles. Many antebellum hospitals, particularly government-funded institutions that cared for the indigent sick, grew out of almshouses whose purpose was to simultaneously extend charitable care and discourage dependence on public relief. As Americans started to take political control of the state of California, legislators sought to replicate the social safety net available to poor individuals in eastern states, including hospital care for the indigent sick. Intent on boosting the town’s economic and political fortunes, leading Angelenos adopted state requirements to obtain funding for the sick poor in the late 1850s. Thus, they embarked on a path to establish structured social services which would shape class relationships in a different way than the vestiges of colonial practices that emphasized less formal means of social and religious obligation. The Daughters of Charity facilitated this transition, choosing to cross ethnic and religious borders to mediate differences that could potentially obstruct their ability to effectively serve people living in poverty. Familiar with American social welfare practices and the expectations of American physicians, the Daughters could communicate effectively with local factions who sought to establish a hospital based on an emerging American model. But, they also capitalized on their religious identity as Catholic sisters to build support among Spanish-Mexican leaders in the city. Deemed suitable caretakers by both English-speaking and Spanish-speaking Angelenos, the Daughters of Charity eased the town’s transition to supporting governmental forms of charitable relief. Beginning in 1858, the sisters collaborated with city and county officials to provide hospital care for the sick poor.

Erika Pérez argues that compadrazgo (Catholic sponsorship and spiritual guidance by those designated as godparents) became an integral part of Spanish colonization in Alta California. As a social safety net (of sorts), it established a set of social relations in which indigenous people obtained food, clothing, and spiritual knowledge in exchange for social deference, and more often than not, labor. To a certain extent, godparents remained socially responsible for their godchildren, providing charitable assistance when necessary and incorporating orphans into ranchero households. Compadrazgo continued into the American period, but ongoing migration and its association with forced Native American labor created difficulties in fully implementing the practice under a new political regime. Erika Pérez, “Colonial Intimacies: Intertexual Kinship, Sexuality, and Marriage in Southern California, 1769-1885” (Ph.D. diss., UCLA, History, 2010), 18-20, 26-28, 285-290; Gunnell, “Women’s Work,” 394-397.
Unusual in its length in the United States, this partnership lasted twenty years.

Although the sisters participated in American-led efforts to transform the city’s social services, this does not mean the Daughters wholeheartedly agreed with the assumptions, methods, or tactics associated with the American conquest. At their hospital, the Daughters of Charity supported bilingual education, and at their hospital, they resisted efforts to transform the institution into an impersonal and punitive poorhouse. Such almshouses tended to perpetuate derogatory stereotypes of the poor based on ethnic or religious differences, and corruption, filth, and disease easily flourished under the guise of deterrence. The Daughters offered an alternative model of dignified care for the body and soul, and this holistic approach tempered the excesses of public almshouse hospitals. While the Daughters of Charity partnered with the Los Angeles County Board of Supervisors to improve medical services for poor persons, they did not want the hospital to become “too American” and rejected the discriminatory practices that tarnished government-funded healthcare in other places.

An analysis of sisters’ partnership with city and county officials offers a rare opportunity to examine the relationship between faith-based institutions and the state in the mid-nineteenth century, thereby illustrating the historical foundations of a struggle that is still relevant in American society today. Chapter one summarizes the philosophical approach of the Daughters of Charity towards nursing and hospital care and sets the stage for the sisters’ work in Los Angeles. Chapter two then explores the establishment of the partnership between the Daughters and Los Angeles county officials. The sisters’ partnership with the city and county illustrates the semipublic nature of social welfare in the mid-nineteenth century, as officials relied on private charitable organizations as intermediaries between the indigent sick and the state.

Chapters three and four explore some of the issues that contributed to the dissolution of the sisters’ public-private partnership in 1878. The 1870s were a key transitional moment in the history of Los Angeles, and in the history of medicine in the United States. As the city transformed from a sleepy Mexican pueblo to a dynamic American city, the Daughters of Charity faced pressures posed by the professionalization of medical services, boosters’ desires to provide “modern” social services as a way to promote the city’s economic growth, and the problems caused by shifting political alliances in a period of economic distress. Combined with concerns that county officials wished to transform the Los Angeles Infirmary into an almshouse, the Daughters decided that continuing their public-private partnership was no longer expedient or advantageous for the community. To maintain their commitment to dignified treatment for those struggling with poverty, they shifted their focus to the private medical market, building a new hospital on Sunset Boulevard and Beaudry Avenue in 1884. Instead of being intermediaries between impoverished individuals and the state, the Daughters of Charity sought new strategies to maintain the financial viability of the hospital and to continue to provide medical care for the indigent sick, thereby fulfilling the responsibilities of their religious mission.

The social, political, and economic changes associated with the city’s urban growth precipitated the dissolution of the sisters’ partnership with the county, and the remaining chapters of the book examine the sisters’ response to the challenges of hospital modernization in Los Angeles. Chapter five examines the sisters’ adaptation to the private medical market in the 1880s and 1890s, “repackaging” the mission, so to speak. The 1884 hospital blended the sisters’ traditions of self-sufficiency with more “modern” aspects of scientific institutions. To keep down the cost of supplies, the sisters maintained a vegetable garden, raised chickens, and grazed cattle on their property. But, the hospital also embraced aspects of Florence Nightingale’s “pavilion-style” architectural design and incorporated space for increasingly popular medical techniques, such as surgery. Significantly, the Daughters of Charity extended care to poor persons by contracting with railroad

Dedicated in 1902, the ‘Annex’ was a six-story hotel-style hospital adjacent to the 1885 structure. Courtesy St. Vincent Medical Center Historical Hospital Conservancy, Los Angeles
company insurance programs, since the majority of these laborers came from working-class immigrant communities. Again, the sisters acted as intermediaries between social and economic institutions and those living in poverty, although this time without government aid. In addition, the hospital admission records housed at St. Vincent Medical Center Historical Conservancy provide practically the only clues about how these railroad insurance programs actually functioned, since the bulk of these records burned with the Southern Pacific Railroad's General Hospital in San Francisco after the earthquake of 1906. Because the railroad programs acted as important precursors to third-party insurance plans that continue to dominate healthcare funding in the United States, the sisters' records represent an important contribution to our understanding of the hospital industry's development both in the west and in the nation as a whole.

Finally, chapter six explores the development of the hospital's nursing school. Nursing schools represented one of the ways that the Daughters of Charity responded to the pressures for the professionalization of nursing and the increased demand for skilled labor in larger hospitals. But most importantly, the schools also fostered the continuity of the community's mission by ensuring that lay nurses understood the sisters' approach to healthcare and their preferential mission to serve the sick poor. The book concludes with the construction of the 1927 hospital on Alvarado Street, a structure that embraced scientific medicine and modernity while also acting as, what Bishop John J. Cantwell described, a “monument to Christian charity.”

Overall, Daughters of Charity demonstrates the adaptability of these Roman Catholic sisters as they adjusted their services both to the demands of the modernizing medical marketplace and to the changing needs of the sick poor in Los Angeles. The Daughters of Charity developed innovative strategies to sustain their institution without compromising their spiritual values as Los Angeles grew from a frontier town to a burgeoning metropolis. By focusing on care for poor persons, the sisters positioned themselves as intermediaries between individuals from different cultures and classes, extending their charitable services without regard to race or creed and acting as a major fixture in the city's nascent healthcare system in the late nineteenth and early twentieth centuries.

“One day,” Sister Angelita Mombrado recalled, “Father [Blaise Raho, C.M.] came to our house and said he had a very sick man for us to take care of. Sister Ann [Gillen] said, ‘Father, where can we put a sick man? We hardly have room for ourselves.’ He said we must find a corner as the man had to be cared for or he would die.” The sisters cleared out the gardener's shed, set up a place for the man there, and nursed him back to health. As Sister Angelita said, “That was the beginning of the hospital in Los Angeles.”

The Daughters of Charity came to Los Angeles on 6 January 1856 intending to open an orphanage and school. Shortly after their arrival, a committee of prominent citizens including Abel Stearns, Ygnacio del Valle, and Augustín Olvera negotiated the purchase of Benjamin D. Wilson's property on behalf of the sisters. Located on the corner of Alameda and Macy streets, the twelve-acre property was ideally suited for an orphanage, complete with seven acres of vineyards, a vegetable garden, and a pure water well. Knowing the international reputation of the Daughters for quality nursing care, Angelenos also encouraged the sisters to open a hospital. Yet, Sister Mary Scholastica Logsdon, the leader of the band, resisted. She wanted to make sure the orphanage, known as the Los Angeles Charitable Institute, was on a secure financial footing before starting a new venture, and the Wilson property had not yet been fully paid for. By bringing a sick man to their door, Father Raho reminded the sisters of their duty to assist the sick poor, and Sister Scholastica relented. And so the Daughters cared for sick individuals at the orphanage until more permanent facilities and funding were arranged.

Roman Catholic sisters from many different religious communities established hospitals throughout the American West in the late nineteenth century.

15 “Program, St. Vincent’s Hospital Dedication,” 1927, Box 35, Folder 15, Office of the President/CEO Records, 1856-1997, SVMHC HC002, SVMCHC, Los Angeles, CA.


Miners, railroad workers, and lumberjacks performed dangerous work. Accidents and injuries were common, and crowded living conditions and poor nutrition also contributed to workers’ vulnerability to illness and contagious disease. Sickness among the largely unattached male workforce was common, but health care options were few. Catholic sisters met this need. Invited by bishops, company officials, or local townspeople, sisters opened hospitals in Colorado, Utah, Montana, Texas, the Dakotas, and other places throughout the west. The Daughters of Charity opened the Los Angeles Infirmary in 1858, one of three hospitals staffed by Catholic sisters on the Pacific Coast in the 1850s. As Christopher Kauffman


19 The Daughters of Charity began nursing patients in Los Angeles in early 1856, but they did not open a separate hospital facility until May 1858. The Sisters of Charity of Providence arrived in Vancouver, Washington, in December 1856, and opened a hospital in March 1858. The Sisters of Mercy arrived in San Francisco in December 1854, and started visiting patients at the State Marine and County Hospital shortly thereafter. During a cholera epidemic in 1855, the county of San Francisco asked the Sisters of Mercy to take charge of the hospital. They maintained the county hospital until July 1857, when the sisters terminated their contract with the county because of lack of payment. The county patients were transferred to the city hospital, and shortly thereafter the Sisters of Mercy reopened the facility as St. Mary’s Hospital. The Daughters of Charity also opened St. Marie Louise’s Hospital in Virginia City, Nevada, in 1875. Kauffman, *Ministry and Meaning*, 100, 121-122; *Our Treasured Past: Daughters of Charity*, 56. See also Anne Elizabeth Hartfield, “Sisters of Mercy, Mothers to the Afflicted: Female-Created Space in San Francisco, 1854 Through the Turn of the Century” (Ph.D. diss., Claremont Graduate University, History, 2003).


21 See: Dinan, *Women and Poor Relief*, 40–43, 104-117; Hannefin, *Daughters of the Church*, 33, 42–46, 50–58, 69–78; Kelly, *Numerous Choirs*, vol. 2, 50–54, 61; Jean Ellen Richardson, *A History of the Sisters of Charity Hospital, Buffalo, New York, 1849–1900* (Lewiston, NY: Edwin Mellen Press, 2005); Libster and McNeil, *Enlightened Charity*, 53–60, 75–79. Sisters of Charity staffed the Baltimore Infirmary in the early 1820s, the Maryland Hospital from 1833–1840, and then opened their own psychiatric hospital in 1840, later named Mount Hope. The Sisters began to manage Charity Hospital in New Orleans from in 1834, when they opened their own hospital, incorporated under the name “Hotel Dieu” (Maison de Sante) in 1845. The Sisters also staffed the Washington Infirmary from 1846 to 1848, and later opened Providence Hospital in 1861. In addition, they established a hospital in Buffalo in 1848, and another in Detroit in 1850. The Saint Louis Hospital, begun in 1828, was renamed Mullanphy Hospital in 1874, when it moved to a new location.
rules also emphasized fiscal responsibility, including a judicious use of time and strict accountability for the use of hospital resources. Combined with the sisters’ earlier acts of selfless service during epidemics, these rules helped the Daughters build a reputation for providing quality nursing care at a reasonable price.

In Los Angeles, the Daughters of Charity played a significant role in the development of hospital care in the city. While the sisters at the Los Angeles Charitable Institute, or Institución Caritativa, began to operate an infirmary for the sick poor in early 1856, they partnered with the Los Angeles County Board of Supervisors and opened a separate hospital to care for the county’s indigent patients in 1858. As the first hospital in the city, the institution was known at various times as the Los Angeles Infirmary, County Hospital, or simply, Sisters’ Hospital. Despite the social prejudices that dominated American society at the time, the Daughters extended services to poor individuals regardless of race or creed, admitting Catholics, Protestants, and Jews into the hospital, as well as native-born Americans, Mexicans, Europeans, and even a Chinese immigrant or two. Committed to upholding their religious community’s spiritual values, the Daughters of Charity steadfastly maintained this stance despite the challenges of racial and class divisions within the city, which were often magnified by precarious economic prospects and political rivalries.

**SISTERS AND DAUGHTERS**

As a recent American convert to Catholicism, Elizabeth Ann Bayley Seton organized the Community of the Sisters of Charity of St. Joseph’s in 1809 and established the religious community’s motherhouse in Emmitsburg, Maryland. Modeled after the French community, the Sisters of Charity expressed Christian devotion through temporal and spiritual service to those living in poverty. Unlike contemplative nuns, these women did not cloister themselves from the world. The Sisters of Charity took simple (annual) vows of poverty, obedience, chastity, and service to the sick poor. They interacted directly with individuals in need through their schools, orphanages, and hospitals. By 1850, they had established schools for girls, orphanages, hospitals, and insane asylums in many places throughout the United States.

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22 “Particular Rules for the Sisters in the Hôtels-Dieu and Hospitals,” *Vincent de Paul: Correspondence, Conferences, Documents*, ed. and trans. by Jacqueline Kilar, D.C., Marie Poole, D.C., et al, 1-13a & 13b (New York: New City Press, 1985-2009), 13b:196-198. Hereafter cited as CCD. Sister Matilda Coskery also developed instructions for hospital sisters during her tenure as the administrator of Mount Hope, a general hospital that specialized in psychiatric care outside of Baltimore in the 1840s. Called *Advices Concerning the Sick*, these instructions illustrated the sisters’ holistic approach to health care, treating the mind, body, and spirit. See Libster and McNeil, *Enlightened Charity*. Since the Regulations of the Sisters of Charity (1812) were based on the *Common Rules of the Daughters of Charity*, Sister Scholastica and her companions would have been familiar with those rules. Sister Ann Gillen, in particular, may have been the most familiar with Coskery’s *Advices Concerning the Sick*, since she served at Mount Hope in 1849.

23 The widow of a New York merchant, Seton converted to Catholicism in 1805. In 1809, Archbishop John Carroll endorsed the Sulpician’s invitation for Seton to establish a school in Baltimore, so that she could better support her children. In 1812, Seton’s Sisters of Charity of St. Joseph’s officially adopted the *Common Rules of the Daughters of Charity* with minor modifications. Arguably, the most significant change allowed the Sisters of Charity of St. Joseph’s to educate girls “in whatever station of life they may be” rather than exclusively working with poor children. The American sisters could then admit boarders into their school, thereby providing income for the community. Hannefan, *Daughters of the Church*, x-xi, 3-18, 58-62; Hebermann, 215-226; Kelly, *Numerous Choirs*, vol. 1, 268. See also Melville, *Elizabeth Bayley Seton*, 1774-1821.

24 According to the agreements developed at the Council of Trent (1545-1563), nuns are religious women who make perpetual (lifetime) vows and generally remain in their convents due to the rules of enclosure. In the seventeenth, eighteenth, and nineteenth centuries, most nuns belonged to contemplative orders which focused on worship and education rather than performing acts of service in the neighborhoods in which they lived. By contrast, sisters make simple (generally annual) vows, and as members of active religious communities they are not required to remain in their convents, or houses. In 1633, Vincent de Paul and Louise de Marillac specifically designed the Daughters of Charity to avoid the rules of enclosure, thus allowing the sisters to work with poor persons directly, either through personal visits at homes or in the sisters’ charitable institutions. Albert J. Nevins, M.M., *The Maryknoll Catholic Dictionary* (New York: Grossett and Dunlap, 1965), 408; Dinan, *Women and Poor Relief*, 3-5, 43-45, 55-57. Sisters of Charity of St. Joseph’s (Emmitsburg), *Souvenir Book*, APSL.
the eastern United States. The religious community managed the first Catholic orphanage in the United States (Philadelphia, 1814), the first Catholic hospital west of the Mississippi River (St. Louis, 1828), and the first Catholic psychiatric hospital in the United States (Baltimore, 1840).25 As the United States expanded further west after the Mexican War, the Daughters of Charity followed, establishing institutions in California, Texas, and Nevada in the latter part of the nineteenth century.

Even after the community’s unification with the French Daughters of Charity many Americans—including the residents of Los Angeles—continued to call these religious women *Sisters of Charity*, rather than addressing them by their proper title. Unconcerned with such formalities in the midst of the exigencies of frontier life, the sisters may not have even bothered to correct their blunder. After all, everybody knew who they were talking about. However, historians should remain attuned to the shifts that accompanied the community’s reorganization. In 1856, Sister

Scholastica Logsdon and her companions came to Los Angeles as members of an international religious community intent on spreading education, health care, and social services for people living in poverty throughout the world. The sisters’ activities (and perhaps, even their presence) in Los Angeles reflect this transnational focus.

Although he had served in the United States since 1838, Bishop Thaddeus Amat, C.M., was originally from Spain, and he used transatlantic connections to raise funds for the new diocese of Monterey and to recruit postulants for the Daughters in 1855. Angelita Mombrado, Clara de Cisneros, and Francesca Fernandez agreed to join and came with Amat to California.26 The original group of sisters who arrived in Los Angeles included these three Spaniards and three Americans. Neither spoke each other’s language. As a result, the American sisters not only encountered a new culture when interacting with the town’s Spanish-speaking residents, but they also faced the difficulties of intercultural communication within their own house. Even so, the Spanish sisters could more easily adapt to speaking the local dialect, a distinct advantage as the sisters sought to gather donations, attract students, and build relationships with the people living there. Despite their challenges, this bicultural band of sisters likely paved the way for local women to be recruited into the sisterhood. Their mission also reinforced the importance of a transnational mindset as American sisters adjusted to membership in an international religious community.

The community’s reputation, experience, and administrative structure prepared the Daughters of Charity to manage the challenges of settling in California during the 1850s. Vincent de Paul and Louise de Marillac had developed a centralized organizational structure based on the Common Rules, yet Susan Dinan asserts that de Marillac purposely maintained enough flexibility to meet local needs. As the religious community grew after the founders’ deaths, the sisters’ seminary training became more structured and their work in hospitals,

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26 Born in Barcelona on 31 December 1811, Thaddeus Amat joined the Congregation of the Mission in 1832, and his superiors sent him to the United States in 1838. Before his consecration as bishop in 1854, Amat served as either faculty or an administrator at seminaries in Donaldsville, Louisiana (1838); the Barrens Settlement, Missouri (1841, 1845); St. Louis, Missouri (1842); Cape Girardeau, Missouri (1844); and Philadelphia, Pennsylvania (1847). In 1850, Joseph S. Alemany was appointed Bishop of Monterey, which at that time included all of California. The population boom that accompanied the Gold Rush warranted the division of the diocese into the Archdiocese of San Francisco and the Diocese of Monterey, which covered central and southern California. Pope Pius IX named Alemany as the Archbishop of San Francisco, while Thaddeus Amat’s name was suggested as Bishop of Monterey. Although his name was first put forth in 1852, Amat did not receive his consecration until 12 March 1854. He arrived in California on 14 November 1855. The diocese was renamed the Diocese of Los Angeles and Monterey in 1859. See Weber, *California’s Reluctant Prelate*, 1-28, 115-118; Mombrado, “Remembrance of My Youth”, *Daughters of Charity in the City of Angels: Sesquicentennial Book* (Los Altos Hills, CA: Daughters of Charity Province of the West, Seton Provincialate, 2006), 8.
orphanages, and schools became more formalized. The Daughters also divided into separate administrative units (called provinces) to better manage local institutions as the community expanded into Poland, Spain, Italy, Russia, and Lithuania by the end of the eighteenth century. Through these efforts, they earned a reputation as effective servants of poor individuals and families and also established a model for other active religious communities to follow, including Seton’s Sisters of Charity in the United States. So, when the communities combined, their international reputation, centralized structure, and independence from the authority of local bishops provided a solid foundation for rapid geographic expansion.

Recognizing the wide range of needs of the poor in a given town, the Daughters of Charity often engaged in multiple charitable works wherever they settled. The sisters opened schools, orphanages, social service agencies, and hospitals. In many cases, they also visited the poor in their homes or offered food to the hungry that sought their assistance. In the mid-nineteenth century, individual sisters could be assigned to an array of institutions, thereby having an opportunity to learn the full range of skills necessary to be an effective Daughter of Charity. During their initial training, or “formation,” young women learned the community’s distinctive approach to religious life, the spiritual significance of caring for the poor, and basic skills that they would need for conducting their ministry, including nursing the sick. Because of the community’s rapid growth, some sisters may not have had the opportunity to become specialists in a particular area. However, all sisters received additional training through informal mentorship programs, and in most cases, sisters worked at several different types of institutions during their lives. Local superiors (called sister servants) routinely paired new sisters with more experienced women to learn teaching, nursing, and leadership skills. Mentoring proved invaluable, building the skills and confidence of young sisters as they applied their religious training to concrete pastoral circumstances.

The centralized structures of community authority also provided great flexibility in managing human and financial resources, experience with different types of institutions in varying settings, and a sense of perspective in balancing the temporal, spiritual, and political demands associated with conducting charitable work.

Sister Ann Gillen encountered a variety of ministry experiences that typified life as a Daughter of Charity during the mid–nineteenth century. Born in Pennsylvania in 1818, Ann Gillen decided to join the Sisters of Charity in Emmitsburg at age twenty-two. Completing her seminary training in 1841, she was then assigned to St. Peter’s Orphan Asylum in Cincinnati, Ohio. While there, Gillen would learn the teaching, management, childcare, and health care skills required to maintain an orphanage. Sister Ann may also have shown an aptitude for nursing, and her superiors sent her for a year of additional training at Mount Hope in 1849, the community’s general hospital and insane asylum located near Baltimore, Maryland. While under the tutelage of experienced administrators and nurses, Gillen and her associates learned the sisters’ holistic approach to nursing, including practical strategies for administering poultices and dressings, providing adequate nutrition, and offering emotional and spiritual support for patients. In addition, Sister Ann may have also studied Advices Concerning the Sick, the ground-breaking training manual developed by Sister Matilda Coskery, Mount Hope’s administrator from 1840 to 1847. In 1850, Sister Ann was sent

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27 Dinan, Women and Poor Relief, 49-53, 118-143.
28 Nelson, Say Little, Do Much, 53-54; Libster and McNeil, Enlightened Charity, 11-52.
29 “Ann Gillen, D.C.”
30 Similar to the practical aspects of the Particular Rules for Hospital Sisters used by the Daughters of Charity in France, Coskery’s Advises emphasized clinical aspects of nursing along with respect for the patient, cleanliness, and a simple diet. The manual also provided basic nursing principles and practical instructions to treat all types of conditions, from burns and fevers to delirium tremens and insanity. Coskery was also a noted pioneer in care for the mentally ill, and her common-sense and compassionate approach drew national attention. She avoided restraints as much as possible, emphasized
to St. Mary’s Asylum and School in Baltimore, where presumably she used her skills as a teacher and nurse. Gillen probably continued to develop her nursing abilities through interactions with other sisters serving in the city, including Sister Mary Ann McAleer, an experienced nurse at the Baltimore Infirmary. Six years later, Gillen was among the six sisters missioned to Los Angeles, and when the Daughters of Charity agreed to open a hospital, Sister Ann was immediately assigned to manage the facility. As demonstrated by Sister Ann’s experiences, mission transfers allowed a Daughter to interact with other sisters to learn different approaches to their work, including problem-solving, relationships with others inside and outside of the community, and strategies to accomplish their day-to-day responsibilities caring for children or nursing the sick. As her skill set grew, a sister was given more responsibilities until she could take on a leadership role at an institution and mentor the next generation of sisters in their traditions.

NURSES AND HOSPITAL ADMINISTRATORS

Vocational nurses such as the Daughters of Charity applied the discipline and structures of their religious community to transfer medical knowledge before secular nursing began professionalization in the 1870s. Conscious of their duty to serve the sick poor, the Daughters offered nursing care in patients’ homes beginning in the 1630s, and they entered the field of hospital management in 1640 when officials asked sisters to staff Saint-Jean L’Évangeliste Hospital in Angers, France. By the time the sisters arrived in Los Angeles, their religious community had over two centuries of hospital nursing experience and its leaders passed down their best practices through a series of rules and mentoring which shaped not only policy and procedure, but also the community’s entire approach to health services. Codified, redrafted, and approved (1646–1655), the final version, organized into chapters, received pontifical approval in 1668 and was promulgated in 1672. The Common Rules of the Daughters of Charity outlined the community’s philosophy, organized the sisters’ daily service, and encouraged personal development in religious life. In addition to the Common Rules, sisters in the parishes, orphanages, hospitals, and prisons had Particular Rules for their duties. Although medical advancements required adaptation, these rules remained relatively unchanged until 1954. Since the Regulations of the Sisters of Charity of Saint Joseph’s (1812) were based on the Common Rules of the Daughters of Charity, Sister Scholastica and her companions would have been familiar with those rules. Nursing manuals, such as Sister Matilda Coskery’s Advices Concerning the Sick, also provided clinical directives regarding cleanliness, diet, and the use of medicines in much the same spirit as the Particular Rules.


33 The Particular Rules for hospital sisters discussed seventeenth-century medical practices such as blood-letting, but the underlying principles of patient care remained the same, as did the sisters’ spiritual exercises and administrative structure. The rules, explained at a series of conferences between 1655 and 1658, were probably a collaborative effort between Vincent and Louise. Codified in 1672, the Daughters of Charity followed the original rules with little modification until 1954. “Common Rules of the Company of Sisters of Charity Called Servants of the Sick Poor Which They Must Keep to Perform Their Duty Well by the Grace of God,” CCD, 13b:147, n.1.

34 When the Regulations and Constitutions for the Sisters of Charity of St. Joseph’s were approved by Archbishop John Carroll in 1812, they largely mirrored the Common Rules of the Daughters of Charity, which bishop-elect John Baptist Flaget, S.S., brought back with him after his 1810 visit to France. These rules were translated by John Dubois, S.S., superior of the Sisters of Charity of St. Joseph’s from 1811 to 1826. Melville, *Elizabeth Bayley Seton*, 1774–1821, 160, 165-166. See also Kelly, *Numerous Choirs*, vol. 1, 243-280. The Regulations, as reprinted in Kelly’s text, do not include the Particular Rules for Hospital Sisters. Sister Matilda Coskery compiled *Advices Concerning the Sick* in the 1840s. It is clinically oriented and reflects the Vincentian tradition of nursing, but not the structure of the Particular Rules. However, Jean-Baptiste Étienne, C.M., Superior General of the Congregation of the Mission and the Daughters of Charity, stressed uniformity in the rules and practices of Daughters of Charity throughout the world during his tenure (1843-1874). The Particular Rules and any other necessary administrative materials were made available to the Americans, although the timing of their transmission and distribution is not clear in the extant record. In May 1850, Sisters Valentine Latouraudais, Vincentia Replplier, Ann de Sales Farren, and Marie Louise Cdsifeld were the first of several delegations which went to Paris for a year of formation (or training) regarding the “religious habit and community customs of the Daughters of Charity.” The sisters would have shared what they had learned with other members of their community in the United States. Kelly, *Numerous Choirs*, vol. 2, 161; Libster and McNeil, *Enlightened Charity*, 44–48, 161-281; Edward R. Udovic, C.M., *Jean-Baptiste Étienne and the Vincentian Revival* (Chicago: Vincentian Studies Institute, 2001), 217, 307-
The Common Rules encompassed the sisters’ approach to institutional management and patient care. Sisters were charged to fulfill their duties to the sick poor “with every possible care and affection, recollecting that it is not so much upon them as on Jesus Christ that they bestow their services.” Coskery instructed nurses that this meant not only the skilled administration of medicinal treatments but also extending kindness to patients, “the remedy of remedies.” Sisters sought to care for the sick poor physically and spiritually by providing food, medicine, and “teach[ing] them the things necessary for their salvation.” As Barbra Mann Wall and Sioban Nelson demonstrate, Catholic sisters sought to integrate their religious and medical missions. Nelson explains, “there was no division for the sisters between devoted and attentive nursing and evangelical work. These were one and the same. It was actually through good nursing that hearts were opened to God and souls on the way to hell were rescued.” Like many other communities, Daughters of Charity had a variety of religious exercises interspersed throughout the day, but the sisters always gave first priority to the needs of their patients.

The sisters’ work ethic and sense of fiscal responsibility also provided a solid foundation for efficient hospital management. The Common Rules discouraged sisters from wasting time, “remembering that God will require an exact account of it.” The rules also prohibited appropriating food, medicine, linen, or money for the sisters’ personal use, “remembering that this would be stealing the property of those who are poor.” This integrity also carried over into an institution’s financial affairs. Sisters were taught to be “strictly scrupulous in the management of money and other things in their charge,” and each house (or establishment) sent an annual report of receipts and expenditures to their superiors. These rules established an effective organizational structure that could be adapted to local conditions with the superior’s permission.

The structure and rules of the Daughters of Charity set their institutions apart from county almshouses and other public hospitals. In the United States, as well as in Europe, public almshouses often doubled as hospitals for the elderly and indigent sick. Almshouses actively discouraged individuals in need from seeking aid — providing a refuge, but making sure life was difficult and uncomfortable. Henry Funk, a night watchman at the San Francisco Almshouse, described the facility as “a human slaughterhouse,” where inmates received little food, wore tattered clothing, and the bed-ridden slept in their own filth. He also witnessed almshouse employees physically and verbally abusing patients. Widespread disdain for the poor opened the door to corruption by administrators and employees. Funds, food, and patient property were often diverted and troublesome inmates could end up dead with little or no consequences. The Daughters sought to eliminate corruption and donated their labor, thus allowing the sisters to provide better care at an affordable cost. But they did not get into hospital work to save the taxpayers money; they sought to serve God by improving the care of poor persons.

In the western United States, Catholic sisters often ran the only hospitals in town, and therefore, they treated Catholic, Protestant, and Jewish patients without distinction. These sisters expressed their religious values of faith, humility, and charity through their daily actions in providing for the physical and spiritual comfort of their patients. By doing so, Wall indicates that sisters engaged in an evangelical mission through providing a “good example,” while avoiding any direct proselytizing of Protestant patients which often raised nativist antagonisms. When invited, the sisters discussed religious values, prayed with and for individuals, and invited priests to administer baptism or other sacraments. Sisters often recorded such conversions with pleasure, celebrating nurses’ opportunities to alleviate suffering, to bring patients closer to God, and to receive God’s grace for themselves. Service

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31 Wall, Unlikely Entrepreneurs, 133.
34 Wall, *Say Little, Do Much*, 113.
35 Known as the “Leaving God for God” principle, acts of service took precedence over personal prayers, although as Libster and McNeil point out, “if [sisters] planned well, they were able to find plenty of time to do both.” Libster and McNeil, *Enlightened Charity*, 121. See also “Common Rules,” CCD, 13b:168; “The Rule of 1812, Regulations for the Society of Sisters of Charity in the United States of America,” in Kelly, *Numerous Choirs*, vol. 1, 254.
37 “Common Rules,” CCD, 13b:151.
to the sick poor was a Daughter of Charity’s “primary and principal duty,” but she also strived to help patients “prepare… for a happy death or to lead a good life.”

To apply the community’s spiritual values and implement its rules, the Daughters of Charity required sufficient autonomy to manage the hospital. Although willing to cooperate with government officials or other administrators, a sister’s first obligation was obedience to their superiors and the community’s Rule. When outside administrators demanded something contrary to the spirit of their mission, or that threatened the community’s values and interests, the sisters resisted. The rules outlined the proper relationship between public administrators and the Daughters. Sister servants would “give an account of their services and management” to administrators, but the Daughters of Charity required public administrators to give the sisters full authority over patient care, hospital employees, and daily operations. Without this type of autonomy, the sisters would “not be able to do the good God wants them to do.” Autonomy remained an important element in the sisters’ ability to control their lives and work, acting in the best interests of their community, and in their determination, the best interests of the people that they served. In a society that often diminished the value of women’s intellectual abilities and labor, the rules bolstered the sisters’ leadership within an institution. When conflicts occurred between the sisters, local officials, or physicians, the sisters relied on their rules to legitimize and justify their independence.

**SUITE TO WORK IN THE WEST**

The demand for the Daughters of Charity to establish missions in California grew out of the impulses that attracted thousands of people to the west in the 1840s and 1850s. Political expressions of “Manifest Destiny” erupted into war along the Texas border, resulting in the American takeover of Mexico’s northern territories in 1848. In December of the same year, President James K. Polk confirmed rumors of the California gold strike, and thousands of Americans joined the Sonoran.


46 Particular Rules for the Sisters in the Hôtels-Dieu and Hospitals,” *CCD*, 13b:187. A similar rule existed in the Regulations of the Sisters of Charity. Article III, paragraph IV states, “[Sisters] will also pay respect and obedience in what concerns the service of the poor to the administrators of the hospitals which may be entrusted to their immediate management hereafter, [and] physicians or other persons who, by their office or out of charity may be concerned in the service of the poor and as nurses, as well as if they are sick themselves.” This passage demonstrates consistency with the Particular Rules of the Daughters of Charity, but note that obedience was only required to administrators in matters concerning the poor, not matters regarding the sisters. “The Rule of 1812, Regulations for the Society of Sisters of Charity in the United States of America,” in *Kelly, Numerous Choirs*, vol. 1, 250.

Chilean, French, Russian, and Chinese miners seeking their fortunes. The changing political boundaries also offered the Catholic Church an opportunity to reinvigorate its presence in California. The secularization of the missions in the 1830s, coupled with continued political instability and frontier isolation, resulted in a diminished institutional presence for the church in California by 1850. Although Pope Gregory XVI appointed Francisco García-Diego y Moreno as bishop of Upper and Lower California in 1840, few priests lived in the diocese and they could not fully meet the pastoral needs of Catholics living in such a vast territory. Bishop García-Diego y Moreno died in 1846, leaving the reinvigoration of the institutional church to others who would work under an American flag.

Pope Pius IX appointed Joseph S. Alemany, O.P., and Thaddeus Amat, C.M., as bishops in the nominally American California in 1850 and 1854, respectively. Although born in Spain, both men lived and worked in the United States for a decade before receiving their appointments in California. In addition, both men understood the value of the religious education and social services that the Daughters of Charity could provide to parishioners struggling with the social and economic consequences of the American conquest. At their request, the Daughters established orphanages in San Francisco in 1852, Los Angeles in 1856, and Santa Barbara in 1858. Although Amat had not asked the sisters to open a hospital, he certainly acceded to the expansion of the sisters’ work when the opportunity emerged in Los Angeles.

To meet the anticipated needs of his new flock, Bishop Amat first applied for French sisters at the headquarters of the Daughters of Charity in Paris. Upon learning that no European sisters were available, he then turned to the motherhouse in Emmitsburg, the headquarters for the newly-established Daughters of Charity Province of the United States. In addition, Amat recruited young men and women to serve in California during his 1855 fundraising tour in Spain, including Mombrado, Cisneros, and Fernandez. Instead of going directly to California, Bishop Amat planned to first take the postulants to Emmitsburg for training. Knowing the young postulants would not at first be capable of managing a mission on the frontier, Bishop Amat implored the director of the Daughters of Charity in Emmitsburg, Father Francis Burlando, C.M., to give him some experienced.


48 When the Sisters of Charity of St. Joseph’s merged with the Daughters of Charity in 1850, Emmitsburg was designated as the headquarters of the Daughters of Charity Province of the United States.
sisters: “I ask of you to have some few Sisters prepared to accompany them to my Diocese, capable to form them in the functions of their vocation: at least you must give me three; I shall not leave Emmitsburg without them. Do not make any objections because I must have them.” 49 Bishop Amat needed experienced sisters to teach the young postulants their responsibilities in religious life. He also needed someone capable of establishing and maintaining an orphanage and school.

On 8 September 1855, the Emmitsburg council responded to Amat’s request by naming three experienced sisters to go to southern California. Sister Mary Scholastica Logsdon (1814-1902) acted as sister servant. Through her previous assignments—including working at two orphanages and helping to establish a new mission in Natchez, Mississippi, in 1847—Sister Scholastica had learned the business, educational, and leadership skills necessary to direct the mission in Los Angeles. Sister Mary Corsina McKay (1810-1888) had been a public school teacher prior to becoming a Daughter of Charity, and she was well-qualified to run a school and to provide teacher training for the young Spanish sisters. To round out the group, Sister Ann Gillen (1818-1902) was a capable nurse, having been trained at Mount Hope in 1849. 50 Although the sisters were few in number, Emmitsburg provided the basic administrative, teaching, and nursing resources that would be required to establish a new mission in Los Angeles.

Unlike other religious communities of women that came west, the Daughters of Charity did not have to radically change their structure and practices to adjust to frontier conditions. The Council of Trent mandated that women religious be cloistered, limiting their participation in and communication with the outside world. Contemplative religious orders tended to rely on support from wealthy patrons, although some communities raised income by conducting convent schools. According to Anne M. Butler, the poverty of western residents made a completely cloistered existence wholly impractical, forcing many of the transplanted European nuns to modify long-standing traditions and funding practices. 51 In contrast, the Daughters of Charity were never subject to the rules of enclosure. In 1633, Vincent de Paul and Louise de Marillac carefully designed the community as a group of “pious lay women with an active spiritual mission of charity,” thereby avoiding being defined as a religious order and circumventing the restrictions that came with it. 52 As an active religious community, the Daughters developed organizational strategies to nurture the sick poor and teach poor children religious fundamentals. Since few wealthy Catholic patrons lived in the United States, the sisters also developed effective methods to maintain their economic independence, including incorporating institutions to protect the sisters’ property rights. Before merging with the Daughters of Charity, Elizabeth Bayley Seton’s Sisters of Charity instituted a three-pronged approach to achieve financial security: earning income from student tuition (or private patients in the case of a hospital), soliciting donations from private benefactors, and entering partnerships with local governments. Well-organized training programs also allowed the sisters to function effectively despite the difficulties of long-distance communication with the motherhouse. Although the sisters still met with difficulties in the west, these traditions and practices prepared the Daughters to adjust to the exigencies of frontier life.

National identity also proved to be a significant advantage in the development of the sisters’ missions in California. The sister servants in San Francisco and Los Angeles were American citizens. With more than fifteen years of experience, both Sister Frances McEnnis and Sister Mary Scholastica Logsdon were very familiar with American social welfare practices in different regions of the country. Sister Frances had served in Cincinnati and St. Louis, Sister Scholastica in New York City, and both served in Natchez, Mississippi. Both women held a national leadership position, serving as the Procuratrix (purchasing agent for the community) at the motherhouse in Emmitsburg, Maryland. 53 Through these experiences Sister Frances and Sister Scholastica learned how to work with clergy, private benefactors, and local government leaders. As Americans in California, the sisters could also connect with the new political order, and these advantages may have eased the sisters’ attempts to garner aid from the newly-established

49 Thaddeus Amat, C.M., to Francis Burlando, C.M., 7 May 1855, Amat Papers, A-149, A-1855, AALA.

50 “Mary Scholastica Logsdon, D.C.”; “Mary Corsina McKay, D.C.,” Entry in Daughters of Charity, Consolidated Database (10-0), APSL; Emmitsburg, Maryland; “Ann Gillen, D.C.”; “Mary Scholastica Logdon, D.C.,” to Francis Burlando, C.M., 7 May 1856,” in Daughters of Charity in the City of Angels: Early Writings, 55–56.


52 Dinan, Women and Poor Relief, 45.

53 “Frances McEnnis, D.C.,” Entry in Daughters of Charity, Consolidated Database (10-0), APSL; “Mary Scholastica Logsdon, D.C.” Born 19 May 1812, Sister Frances (Mary Ann) McEnnis became a Sister of Charity at age sixteen. Before coming to San Francisco, she served in St. Peter’s Orphan Asylum in Cincinnati (1830-1833); St. Louis Hospital (1833-1834), and St. Louis Asylum (1834-1846) in St. Louis; St. Joseph’s School in Washington, D.C. (1846-1847); in Emmitsburg as Procuratrix (1847); and at St. Mary’s Asylum in Natchez, Mississippi (1848-1852). Born on 2 March 1814, in Westminster, Maryland, Sister Mary Scholastica (Honoria) Logsdon became a Sister of Charity at age twenty-five. Before coming to Los Angeles, she served in the Half-Orphan Asylum in New York City (1841-1846); St. Mary’s Asylum and School in Natchez, Mississippi (1847-1849); and in Emmitsburg as Procuratrix for the community (1849-1856). Both sisters became Daughters of Charity when the American Sisters of Charity united with the French in 1850. Upon their arrivals in California, Sister Frances had twenty-four years of experience, Sister Scholastica seventeen.
state government. In Los Angeles, the sisters’ status as American Catholics also proved to be an effective marketing tool. The Daughters of Charity offered an “American education,” attracting students whose parents wanted their children to succeed in English-speaking society. Thus, state aid and tuition dollars allowed the sisters to house, feed, and educate the orphans who needed their care.

The Daughters of Charity also possessed several characteristics that made them attractive healthcare partners for the Los Angeles County Board of Supervisors. When considering such a partnership, the availability of skilled nurses remained paramount to the board, but the language abilities and religious affiliation of the Daughters also made the arrangement more politically palatable. A shared religious affinity would have appealed to Spanish-Mexican members of the board, while having English-speaking nurses and administrators also pleased the politically savvy Americans who hoped to boost the city’s economic prospects with improved public health services. This partnership appeared to be something that everyone could agree on.

**INTERCULTURAL ENCOUNTERS**

When analyzing the actions of the Daughters of Charity in Los Angeles, it is useful to remember that these women could not completely divorce themselves from the prejudices of their day, despite the sisters’ best efforts to practice the virtues of humility, simplicity, and charity through service to poor persons.54 Born in Maryland, Sister Mary Scholastica Logsdon grew up in a slave state, surrounded by a society that privileged whites over blacks, Native Americans, and mixed-race peoples. Growing out of colonial contests for land and power in the seventeenth and eighteenth centuries, many European settlers used their notions of racial difference to demarcate the line between “civility” and “savagery,” and they applied these ideas to justify white dominance over land, labor, and politics. Lacking an understanding of, and likely respect for, cultural differences in kinship patterns, the sexual division of labor, and religious practices, colonists tended to label blacks and Native Americans as indolent, immoral, and irrational.55 Justifications for the continuation of black slavery, and a thirst for the acquisition of Native American territory, fostered further development of this racial ideology, ensuring that it was thoroughly ingrained into nineteenth-century American society. Even Catholic missionaries who believed that nonwhites were “reformable” sometimes had difficulty relinquishing racial stereotypes upon their first intercultural encounters. However, in Sister Scholastica’s case, initial impressions mattered less than the long-term results of those interactions.

During the 1850s, the Daughters of Charity participated in the transcontinental migration that accompanied U.S. territorial expansion. Through the Treaty of Guadalupe-Hidalgo, the U.S. government acquired the western territories which facilitated overland travel to California. But, overland migration remained difficult and dangerous. Migrants experienced poor roads, inadequate provisions, sickness, Native American attacks, and bad weather. Even under ideal circumstances, the trip from the Missouri River to California could take four months. In contrast, migrants could travel by ship from New York to San Francisco via Panama in as little as six weeks by 1850.56 Five years later, transportation improvements cut the time to less than four weeks. Travelers still struggled with cholera and malaria in the tropical climate, but the promise of a speedier route to the Pacific made it worth the risk. Anxious to take advantage of the enormous profit-making opportunities to transport goods, people, information, and gold between the two coasts of the United States, the Panama Railroad Company sought government support (from both the U.S. and Nueva Granada) to improve transportation across the isthmus.57 California’s gold rush transformed Panama’s economy as 218,546 passengers crossed from the Atlantic to the Pacific between 1848 and 1860.58

As part of this process, American migrants confronted a society in which people of color exercised a considerable amount of economic and political power, at least compared to their counterparts in the United States. Nueva Granada abolished slavery in 1852 and the government extended universal manhood suffrage in 1853. The U.S. would not completely abolish slavery until more than a decade later, and African American men did not gain the right to vote until the passage of the Fifteenth Amendment in 1870. Historian Aims McGuinness also notes that people of color made up the majority of the boatmen, porters, and muleteers on whom migrants relied to cross the isthmus before the completion of the railroad in 1855. Unused to being dependent on persons they would consider social inferiors at home, the situation disrupted some white migrants’ sense of a “natural” racial hierarchy. As a result, some American travelers found


57 Panama remained part of the nation of Colombia, called Nueva Granada until 1863, and declared independence in 1903. *Ibid.*, 189-191.

the migration experience disconcerting, while others proved openly hostile.\(^{59}\)

Whatever their individual response, Panama represented an introduction to the multiracial environment white migrants would face in California.

Because they arrived after the Panama Railroad was completed, Sister Scholastica and her companions were, by and large, insulated from any unpleasant intercultural encounters during their sojourn on the isthmus. Sister Scholastica, Sister Ann, and the three Spanish sisters traveled in a large party that included Bishop Amat, his secretary Father Sorrentini, several priests, and a dozen Sisters of Providence bound for Chile. Amat made all of the travel arrangements, secured food and lodging, and offered spiritual consolation by celebrating mass during their journey.\(^{60}\)

The party arrived in Aspinwall aboard the steamer *Empire* on 29 October 1855. After staying on the steamer overnight, the party took a five-hour train ride to Panama City.\(^{61}\) Logsdon admired the green scenery and the abundant citrus fruits, but like other American travelers, she had some preconceptions about the dark-skinned Panamanians who inhabited the isthmus. Not accounting for the differences in climate and presumably unaware of the spike in unemployment caused by the completion of the railroad, she lamented the natives’ living conditions: “What a lovely country might be made of this, if the inhabitants were only industrious.”\(^{62}\)

The short length of the journey gave Sister Scholastica little time to dispel these notions, but notably, she was not as severe on the Panamanians as some other American travelers, who labeled them “savage,” “mongrel,” or “indolent.”\(^{63}\)

Her journal also illustrates a measure of compassion for native peoples, although she had no direct interaction with them during her short time in Panama.\(^{64}\)

On the evening of 30 October, the sisters boarded the steamer *John L. Stephens* to take them north along the Pacific coast. They arrived in San Francisco on 14 November, and after a month’s rest, Sister Scholastica and her companions continued on to Los Angeles by ship.

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\(^{60}\) Mary Scholastica Logsdon, D.C., “Journal of Ocean Voyage to California,” in *Daughters of Charity in the City of Angels: Sesquicentennial Book*, 28, 30-32. Amat also found a steamer company willing to give the sisters and missionaries a twenty-five percent discount on their accommodations. Thaddeus Amat, C.M., to Francis Burlando, C.M., 24 June 1855, Amat Papers, A-151, A-1855, AALA. Sister Mary Corsina McKay was already serving in San Francisco and did not make the transcontinental journey with Sister Scholastica.

\(^{61}\) The Panama Railroad Company completed the railroad in late January 1855. The first steamer passengers to cross the isthmus completely by rail did so on 29 January 1855, although the official celebration of the railroad’s completion occurred on 15 February 1855. Kemble notes that these passengers reached Panama in four and one-half hours. Kemble, *Panama Route*, 189. By 1862, the Panama Railroad Company reduced travel time to between three and four hours, departing each morning from Aspinwall at 8:15 A.M. The company also arranged for a special train to leave within one hour of a steamer’s arrival, minimizing the time that passengers spent on the isthmus. F.N. Otis, *Illustrated History of the Panama Railroad* (New York: Harper and Brothers, 1862), 56, 139. Sister Scholastica writes that the sisters left Aspinwall after breakfast at 9 A.M. and arrived in Panama by 2 P.M. on 30 October 1855. Logsdon, “Journal of Ocean Voyage,” *Ibid.*, 30.

\(^{62}\) Logsdon, *Ibid.* Aims McGuinness asserts that the completion of the Panama Railroad decimated the local economy on the isthmus. Jobs for boatmen and muleteers disappeared, as did construction jobs when the last rail was laid. In addition, business for food peddlers, suppliers, and hotel operators dried up along most of the route, as did their need for employees. McGuinness, *Path of Empire*, 31-49, 77-80.


\(^{64}\) For example, when people she believed to be “Indians” begged for money during the steamer stop at Acapulco (en route from Panama City to San Francisco), Sister Scholastica commented, “Poor creatures, it is shocking to look at them; they appear unconscious of their condition and enjoy life as much as anyone.” *Ibid.*, 33.
On 6 January 1856, six Daughters of Charity appeared in the plaza of Los Angeles. The sisters had taken the four-day journey from San Francisco aboard the steamer Sea Bird. Arriving unexpectedly, no one met them at San Pedro and the sisters accepted a ride to town from a fellow passenger. Shortly after their arrival, “a good, aged, Father came in puffing and blowing and signed for us to follow him.” He escorted them to the home of Ygnacio and Ysabel del Valle who hosted the sisters until the bishop returned from San Gabriel two days later. Bishop Thaddeus Amat had expected the sisters to arrive in February, but since his instructions were a little vague, Sister Scholastica had taken advantage of the opportunity to come right away. Upon receiving Amat’s letter, Sister Scholastica reported, “Americans like [us] we posted off in the next boat.” The sisters stayed at the del Valle home until they were able to move to the orphanage property a few weeks later.

Upon their arrival in Los Angeles, Sister Scholastica Logsdon and her companions faced as foreign an environment as they had encountered in Panama, with the exception of the green scenery. A small town of less than two thousand people, Los Angeles was known as “rough country even for California.” “Negro Alley” remained the center of vice and violence in the pueblo, housing several dozen bars, brothels, and other disreputable businesses. In his memoir Sixty Years in Southern California (1916), Harris Newmark remembered, “Human life at this period was about the cheapest thing in Los Angeles, and killings were frequent.” He estimated that Los Angeles averaged one murder per day, much of it attributable to bar-room brawls and other alcohol-induced disputes. Political instability added to the lawlessness. Before the Mexican War, economic difficulties made it difficult for city officials to collect enough revenue for city improvements and law enforcement. Widespread apathy resulted in low voter turnout, and at times, Common Council members—the town’s official governing body—had to be threatened with fines in order to attend their sessions.

Although the conditions improved somewhat in the 1850s, Los Angeles continued to struggle with a culture of violence. During a visit in late 1854, a Presbyterian missionary, Reverend James Woods, commented that Los Angeles might better be called “the city of Demons.” In the first two weeks of his stay, Woods noted eleven deaths in his diary, “and only one of them a natural death—all the rest by violence.” Woods blamed rum for most of the violence, but also noted its racialized character: “Many of these are of the low drunken mexican or indian class.” He also called Sunday’s horse-racing, gambling, and rabble-rousing “the fruits of popery,” and complained that even the “leading people of the aristocracy…[were] a dark complexioned set with darker minds and morals.” Although racial bias certainly compounded Wood’s perceptions of “the city of Demons,” Angelenos did grapple with violence and vice throughout the decade and lacked the stabilizing social order that Woods felt religion would bring to the town.

Since its founding in 1781, Los Angeles maintained a multiethnic and multiracial character. Most of the forty-four original pobladores, or founders, had mixed European, Native American, and African heritage. Retired soldiers from the Spanish presidios also settled in the region as did other immigrants from Sonora and Sinaloa, in what is now northern Mexico. The settlers often married Native American women, and although Spanish was the dominant language, cultural blending characterized Los Angeles. Known as the gente de razón, these people were Spanish subjects, practiced Catholicism, and largely rejected Native American folkways. After Mexican independence in 1821, most of those born and raised in the territory had greater loyalty to the land of their birth than to a far-off government in Mexico City, and they started to refer to themselves as californios and californianas. The most enterprising (and well-connected) californios garnered large land grants from the Mexican government in the 1820s and 1830s, transforming land ownership into wealth by raising cattle for the hide and tallow trade. These rancharios rose to the top of californio society, and many sought to secure their economic and social positions through intermarriage with other elite families. European or American men, such as Abel Stearns, also married into ranchero families, thereby gaining access to their father-in-laws’ business and political connections. Even though many ranchero families had some Native American
ancestry, their wealth assured these *californios* high social standing. Yet, some white Americans like James Woods still could not get past their dark complexions. By the time the Daughters of Charity arrived in 1856, Los Angeles society had further diversified. Native Americans and working-class Mexicans continued to dominate the laboring classes, but Irish, German, Italian, and American migrants were among the town’s merchants and professionals. *Ranchero* families such as the Sepúlvadas, Bandinis, Lugos, and del Valles formed the upper crust of pueblo society, although Anglo-Americans started to challenge their political power in the 1850s. Los Angeles also had a sizeable French community, numbering about four hundred by 1860, as well as fourteen Chinese immigrants and a small African American community.74 The city teemed with cultural diversity, and people of color held economic and political positions that would have been prohibited in many eastern states. Spanish remained the common language, and many newcomers would have been uncomfortable with the extensive violence and vice present in the town. For Sister Scholastica, Los Angeles probably felt like a foreign land, not part of the United States of America.

Considering the racial ideology which dominated the United States at the time, how did the sisters respond to this “foreign” culture? In her second letter from Los Angeles, Sister Scholastica commented on the ignorance andindle that appeared to dominate the pueblo. Although she blamed sin and moral corruption for these conditions, Sister Scholastica’s observations mirror her racial perceptions of Panama.75 However, closer interaction with local people dispelled the sisters’ prejudices. Sister Scholastica moved beyond her initial impressions to build cooperative relationships with those from different cultural backgrounds. She rarely made negative comments about the town or its residents in her letters, and these observations disappeared completely from her correspondence within a year. The Daughters of Charity established a bilingual school, and the students’ public performances included recitations in both English and Spanish. In February 1856, Sister Scholastica reported that only one of the sisters’ sixty-eight students was American. The Daughters also quickly accepted *californianas* into their religious

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74 The Chinese immigrants engaged in entrepreneurial ventures such as laundries, peddling agricultural goods, and running gambling establishments. Peter Biggis, a former slave who arrived in 1852, was also an independent businessman and became the town’s first barber and bootblack. William David Estrada, *The Los Angeles Plaza: Sacred and Contested Space* (Austin: University of Texas Press, 2008), 56–72.

75 “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 29 February 1856,” in *Daughters of Charity in the City of Angels: Early Writings*, 49–50.
mobility with an “American” education to all their students, and maintaining a tangible link between Spanish-Mexican Catholics and a changing church.

CONCLUSION

In January 1856, the Daughters of Charity came to Los Angeles intending to establish an orphanage and school. Devout Spanish-Mexican Catholics, such as the del Valle family, immediately embraced the sisters as comforting representatives of the church, and over the course of the next two years, the Daughters extended their benefactor network across cultural and religious networks. French and German Jews, American Protestants, and Irish and Spanish-Mexican Catholics supported the sisters’ educational endeavors either by sending their children to the school or contributing to the sisters’ fundraising efforts. However, Angelenos quickly surmised that the sisters’ contributions to their community could extend beyond education. In his announcement of their arrival, J.S. Waite, the editor of the Los Angeles Star, merged the sisters’ educational and medical missions. He encouraged residents to donate generously to the fund to purchase Benjamin D. Wilson’s property, speculating that the twelve-acre parcel could easily accommodate both an orphanage and a hospital. In one fell swoop, Waite asserted that Angelenos could vastly improve the state of the city’s education and health care services: “Los Angeles is not without her fatherless children, her neglected sick, her uneducated poor; and we are sure... that she will respond with a liberal hand... to secure this additional and most efficient means for their protection and care and improvement.” Angelenos saw the potential value of establishing an orphanage and hospital in their relatively isolated settlement, but still hoped to accomplish the task as cheaply as possible.

While Sister Scholastica Logsdon certainly appreciated Waite’s efforts to raise capital on the orphanage’s behalf, she was understandably reluctant to commit to doubling the scope of the sisters’ work. She had one teacher, one nurse, and three new sisters with only four-and-a-half months of training each. Understaffed, with little prospect of reinforcements being sent from Emmitsburg because of the expense of the journey, Sister Scholastica likely worried about overburdening her companions. Language barriers added another layer of complexity to the situation. When they arrived, the American sisters spoke no Spanish, and the Spanish sisters spoke little or no English. Managing the day-to-day communication within the house must have been challenging, let alone conversing with students, parents, and benefactors.

Funding remained another source of concern. Despite Waite’s noble intentions and support from the town’s leading families, a drought took its toll on the region’s ranching economy, drying up donations in the aftermath. By the end of 1856, the subscription committee had only collected half of the agreed purchase price for Wilson’s property. To open a hospital, the sisters needed a building, furnishings, and staff, not to mention funds to cover the daily costs of feeding, clothing, and administering required medicine to patients. Plus, Sister Scholastica may not have wanted the primarily male patients too close to the girls living at the orphanage. Another site would be more advantageous both to treat disease and to maintain social propriety. Given the human and economic capital required to adequately manage a hospital, it is easy to see why Sister Scholastica delayed opening one immediately.

Nevertheless, she reported to Father Burlando, in Emmitsburg, “Our friends here are very anxious for us to put up a room, as they call a small building, and take charge of the poor sick until such a time as a Hospital could be built, as they say the people need something of the kind, to convince them that we are really going to remain. They say so many things have been commenced here, and have never succeeded.” Growing community demand probably encouraged Father Raho to force the issue by leaving a sick man on the sisters’ doorstep. The sisters would then begin caring for the city’s sick poor, even without a hospital. Nursing the sick at the Institución Caritativa encouraged greater community confidence in the sisters, a necessity in building the social and political relationships and capital that sustained their mission to the poor.

See Gunnell, “Women’s Work.”


In a letter to Father Burlando dated 29 February 1856, Sister Scholastica wished she could speak Spanish so that she could talk with Sister Francesca Fernandez, who was having difficulty adjusting to life as a Daughter of Charity. However, the letter also reveals that Sister Scholastica intended to learn the language. She likely did so, since she signed a letter to Ysabel del Valle written in Spanish in 1870. Admittedly she could have dictated the letter to a translator, but there is a good possibility that Sister Scholastica learned to write and speak Spanish during her time in Los Angeles. Logsdon to Burlando, 29 February 1856; Mary Scholastica Logsdon, D.C., to Ysabel del Valle, 26 January 1870, Del Valle Collection (1002), Document 814, Box 6, Seaver Center, Los Angeles.

Influential men such as Augustín Olvera, Ygnacio del Valle, Antonio F. Coronel, David W. Alexander, and Benjamin I. Hayes lent their reputations to the effort, thereby marshalling the social, economic, and political backing needed to raise the necessary funds. In early 1856, the committee negotiated the purchase of Benjamin D. Wilson’s property on Alameda and Macy Streets for $8000, and they raised about $4000 by the end of the year. “Public Meeting,” Los Angeles Star, 22 December 1855; “Resolucion De La Commision Encargada Del Establisimiento De Las Hermanas De La Caridad, en Los Angeles, California, 1856,” 7 February 1856, Maryvale Historical Collection, Box 3, Folder 3, Maryvale, Rosemead, CA; “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 21 November 1856,” in Daughters of Charity in the City of Angels: Early Writings, 61-62. Bishop Amat renegotiated the terms of payment with Benjamin Wilson, and paid him $2000 in August 1857. The bishop then left the remaining $2000 for the sisters to raise during 1858. “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 23 June 1857,” Ibid., 71-72.

The Daughters of Charity also filled a void in the city's social welfare services. Much like other nineteenth-century women's charity organizations, the sisters initiated an institutional response to alleviate the suffering of the sick poor. Starting in a rented adobe in May 1858, the Daughters of Charity opened the first hospital in Los Angeles. Although the conditions were rather rudimentary, the hospital included a room for private patients and a charity ward. The sisters provided nursing and domestic labor free of charge, but they billed the county for food, bedding, and medical supplies for those admitted as charity patients. When the opportunity presented itself, they expanded the institution, purchasing property in October 1858 and January 1861. Although the county paid for the hospital's initial start-up costs, the Daughters owned and operated the institution by the end of 1858. The sisters incorporated the hospital as the Los Angeles Infirmary in 1869, and to ensure they retained control of the institution and its policies, all members of the corporate board were Daughters of Charity. However, the county continued to pay for the daily maintenance of charity patients. Even though the Los Angeles Infirmary was a private institution, the sisters' reliance on county funds circumscribed their autonomy somewhat. The sisters had to carefully navigate the political pressures that came with government-funded healthcare: negotiating admissions policies and procedures; balancing the relative power of physicians, administrators, and county officials in institutional decision-making; and acquiring adequate funding to provide patients with quality care.

Like other antebellum hospitals, the Los Angeles Infirmary began as a social welfare institution. In an era when hospitals had few advantages over home care, patients rarely chose these facilities if they had any other options. Government-funded institutions, in particular, tended to admit the homeless, the elderly, or the very poor. Since this was the population that the Daughters of Charity intended to serve, collaboration with public officials made sense. This chapter analyzes the establishment of the sisters' partnership with Los Angeles county officials, as well as the benefits and pitfalls of this relationship. As scientific medicine took hold in the 1880s, many hospitals, including the Los Angeles Infirmary, moved beyond their roots as social welfare institutions and
embraced the private medical market. While this process will be explored further in chapters five and six, placing the sisters’ hospital within the matrix of American social welfare institutions helps us to better understand the involvement of the Daughters in hospital care. Because the sisters approached their hospital work as a means to serve the sick poor, their institutions remained mindful of these individuals even when the early twentieth-century demands for larger facilities, new technology, and modern medical techniques encouraged other American hospitals to concentrate almost exclusively on attracting private patients.

HOSPITALS AS SOCIAL WELFARE INSTITUTIONS

Like many other charitable institutions of the nineteenth century, the sisters’ hospital in Los Angeles operated as a private institution conducted in the public interest. Orphanages, hospitals, houses of refuge, and other social institutions to aid the poor claimed their establishments benefited the entire community by reducing crime, containing disease, or educating good citizens. In short, many nineteenth-century benevolent associations operated charitable institutions as a means to contain the inescapable problem of poverty, and they appealed to local governments and wealthier individuals to support their institutions for providing this service. Advocates for charity institutions often couched their appeals in language that emphasized Jewish or Christian religious duties to care for the poor, but they also built on legal precedents established by the British Poor Laws, which empowered local governments to use tax money for poverty relief. Colonial Americans adapted British poverty relief policies to meet their local needs in the seventeenth and eighteenth centuries, and by the mid-nineteenth century, many counties operated almshouses which functioned as catch-all facilities to house the unemployed, orphaned, inebriated, elderly, disabled, or insane. Most poorhouses also had rudimentary hospital wards.

Social welfare policies fostered the growth of hospitals in the United States. Both Philadelphia General Hospital and Bellevue Hospital in New York began as public almshouses. In the first decade of the nineteenth century, the Philadelphia almshouse admitted between 1,300 and 2,100 hospital patients each year, and the almshouse had thirteen hospital wards for women and sixteen wards for men by 1826. However, dirty wards, the threat of hospital-borne diseases, and the social stigma of dependence discouraged “respectable” persons from going to the almshouse. Historian Charles E. Rosenberg explains that “One of the fundamental motivations in founding America’s first hospitals was an unquestioned distinction between the worthy and unworthy poor.” Since most Americans stigmatized almshouse residents as indolent, intemperate, and immoral, socially-conscious citizens started to organize voluntary hospitals for the hard-working, church-going and otherwise respectable men and women who fell victim to accident or serious illness.

Voluntary hospitals, named because they were supported with charitable contributions, reflected class-based definitions of social respectability. Although they generally accepted both paying and non-paying patients, charity patients made up a majority of the hospital population before 1870. However, Rosenberg contends that voluntary hospitals tended to limit admissions to “curable patients of good character.” Those afflicted with venereal disease, alcoholism, contagious diseases like typhus and smallpox, or incurable cancers were often denied admission to charity wards. Venereal diseases and alcoholism were considered evidence of immorality, contagious diseases threatened other hospital patients, and incurable diseases raised the hospital’s death rates and tied up hospital beds with those needing long-term care. Some hospitals required recommendations from applicants to assure trustees of their good character, a requirement that reinforced a preference for long-time residents. As the need for clinical medical education grew, physicians turned to voluntary hospitals to gain experience. However, the most common prescription for hospital care before the Civil War remained “rest, warmth, and a nourishing diet.” As hospital reformer Dr. W. Gill Wylie commented, hospitals were social necessities to “shelter the sick and the helpless,” providing a temporary home for those who had none.

The impulse to establish Catholic hospitals developed in response to the insensitivity, if not outright prejudice, towards immigrants and their differing

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83 Mary P. Ryan, Civic Wars: Democracy and Public Life in the American City during the Nineteenth Century (Berkeley: University of California Press, 1997), 104.


85 Rosenberg, Ibid., 111-113.


87 Ibid., 23.

88 Ibid., 22-30.

89 Ibid., 27.

opportunities to reclaim those who had strayed from the faith. Catholic-owned hospitals were being denied the sacraments, and they also remained concerned about lost patients who had Catholic religious backgrounds. Clergy worried that good Catholics would lose their religious faith because “The nearer a hospital resembles what we understand as expressed in the word home, the better it is.”

During the first half of the nineteenth century, and while these institutions remained nominally secular, leaders routinely opened their doors for Protestant religious groups who wished to reform (and/or convert) charity patients. Beginning in 1812, the Interdenominational (Protestant) Society for Supporting the Gospel among the Poor organized members to pass out tracts, read scriptures with patients, or to conduct religious services in public hospitals. By 1840, most municipal hospitals also had a paid Protestant chaplain on staff. During the next two decades, however, hospital administrators often made it difficult for Catholic clergymen to meet the spiritual needs of Catholic patients. At Bellevue and other city-owned hospitals, priests were allowed to visit patients, but the city alderman refused to pay them a salary. The Jesuit Fathers at St. Francis College also complained that hospital officials refused to allow them to administer the sacraments. At the privately operated New York Hospital, Catholic priests could only visit patients if specifically requested, making it difficult for clerical agents to reach all patients in need of spiritual sustenance. Because a majority of charity patients had Catholic religious backgrounds, clergy worried that good Catholics were being denied the sacraments, and they also remained concerned about lost opportunities to reclaim those who had strayed from the faith. Catholic-owned hospitals posed a solution to these problems, as was evidenced by the decision of the Sisters of Charity of New York to open St. Vincent’s Hospital in 1849.

Even though the opposition to Catholic clergymen’s presence in New York’s public hospitals started to subside during the Civil War, Catholic sisters from many different religious communities continued to open hospitals as a means to offer spiritual comfort to their coreligionists in distress. Sisters responded to a strong impulse to “care for their own,” and the Irish, German, and later Italian, religious communities tended to cater to members of their own ethnic group, adding cultural familiarity and a common language to the spiritual nurturing offered in their hospitals. In the west, however, the Catholic population rarely had the resources or numbers to support a hospital, and sisters had to reach out beyond those boundaries to meet the needs of all those in the isolated towns of the region.

The social constructions of gender, poverty, and medicine also shaped Catholic sisters’ involvement in nineteenth-century hospital work. Historian Paula Baker argues that women developed a separate political subculture before the Civil War, based on women’s elevated moral authority as guardians of the home. Many reformers embraced this “political domesticity” and justified women’s increased public involvement as advocates for poor women and children. Middle-class women engaged in community service, moral reform, and the care of dependents, as reformers sought to redefine women’s place in the community through an expanded vision of “home.” As Baker explains, “home [became] anywhere women and children were.” While Catholic sisters did not see their actions as political (nor did many other women, for that matter), the gendered antebellum political subcultures provided opportunities for communities of women to engage in social welfare work, particularly in nursing and the care of dependent children. Cultural images that magnified women’s moral natures solidified their position as the most appropriate caregivers, nurturers, and teachers.

Women’s ability to “create a home” also facilitated their entrance into hospital work. Dr. W. Gill Wylie lobbied for women’s involvement in hospitals because “The nearer a hospital resembles what we understand as expressed by the word home, the better it is.” Charles Rosenberg also asserts that early hospitals acted as extensions of “home.” Superintendents watched over their “children,” providing them with food, housing, and nurturing care. Before 1890, hospital architecture differed little from large homes and had few specialized spaces for surgery, diagnosis, or treatment. Food, fuel, and labor dominated hospital budgets, and Rosenberg notes these were “costs little different from those of an orphanage, boarding school, or rich man’s mansion.”

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92 McCauley, Who Shall Take Care of Our Sick?, 3.
93 Ibid., 5, 7.
94 Ibid., 16.
97 Wylie, Hospitals, 78.
cases, hospital managers actually converted large homes into medical spaces.99

In this social climate, Catholic sisters provided a good fit as hospital managers. Living outside the nuclear family and not having children of their own, sisters exercised a sort of “maternal” nurturing influence over the poor men, women, and children in their care. The habit, a clear marker of religious identity, separated sisters as distinct and asexual, providing them with a veil of cultural protection which allowed them to operate in the public sphere, both when nursing their primarily single male patients and in exercising managerial authority with city officials, benefactors, and other business owners. In a non-specialized medical atmosphere that blurred the boundaries between hospital and home, Catholic sisters capitalized on gendered prescriptions of domesticity, even while they stepped beyond traditional boundaries into entrepreneurial activities and social advocacy for the poor.

The Los Angeles Infirmary provides an interesting case study to illustrate the interactions of gender, medicine, and social welfare practices. As part of a newly-conquered frontier, Mexican and American social welfare practices. Traditions of public-private collaborations, as well as the expediency of frontier isolation, encouraged Angelenos to partner with the Daughters of Charity in establishing southern California’s first hospital. However, distrust of the poor combined with unfavorable economic conditions in the 1860s to create tensions between the county and the sisters about the qualifications for aid and cost of patient care. The sisters had to negotiate a political space in which they could maintain their autonomy in the hospital’s management, secure continued public funding, and provide the type of care consistent with their mission.

HEALTHCARE IN LOS ANGELES BEFORE THE SISTERS’ ARRIVAL

Local interpretations of public responsibility for social welfare shaped the development of the Los Angeles Infirmary. California’s American and Spanish-Mexican residents drew on similar social welfare traditions that encouraged local governments, private charitable organizations, and individual philanthropists to engage in collaborative efforts to care for a community’s orphans and indigent sick. The American and Spanish-Mexican systems differed in their emphases, but both embraced the concept that the public had some responsibility to care for the community’s poor. Mexicans tended to rely more on religious organizations, such as the Daughters of Charity, to provide social welfare services, while Americans developed a more legalistic system that emphasized local government’s responsibility to care for its poor residents through county poorhouses.100 Both systems engaged in public-private collaborations, but differences continued due to local economic resources and changing political attitudes towards the poor.

As California transitioned from a Mexican territory to an American state, legislators reconfigured social welfare practices to meet the state’s changing social and economic conditions. As Anglo-Americans gained more political power, American notions of limited public responsibility for the poor tended to take precedence in the construction of state welfare law and its interpretation on the local level. Although the legislature provided limited subsidies for private benevolent organizations to provide relief for poor women and children in the 1850s, the state primarily focused its welfare efforts on relief for the indigent sick. In 1852, the legislature appropriated $25,000 to establish aid stations, hire doctors and nurses, and transport those migrants who succumbed to illness while crossing the Sierras to the Sacramento State Hospital. It also approved the establishment of state hospitals in San Francisco (1850) and Stockton (1851) to treat the sick migrants who flooded into the state during the height of the Gold Rush.101 However, by 1855, the tide had largely subsided and the legislature restructured public responsibilities to care for the sick poor. It instated the American social welfare tradition of charging counties with caring for the indigent. In that same year, the legislature authorized the collection of passenger fees from those traveling by sea to the state, the proceeds of which would be placed in a state hospital fund. These funds would then be proportionately distributed to each county according to population, as recorded by the 1855 state census. The legislature designated these funds for treatment of the indigent sick, and also authorized boards of supervisors to levy taxes for a county hospital fund, as long as the tax was less than one quarter of one percent of the value of an individual’s real and personal property.102

Prior to the arrival of the Daughters of Charity, Los Angeles maintained an ad hoc system to care for its sick. In response to the new law, the Board of Supervisors established a sub-committee to better manage the expenses for the county’s indigent sick in July 1855. At the time of treatment, the Committee of Health approved individual applications for county support. Doctors, pharmacists, and boarding house owners then submitted their approved expenses to the Board of Supervisors quarterly to receive payment. Notably, prescriptions had to be submitted in English, and the county physician had to be a “regular graduate” from a recognized medical institution.


100 Katz, In the Shadow of the Poorhouse, 11, 37, 43-54, 61; Jacobus tenBroek, “California’s Welfare Law—


101 tenBroek, Ibid., 279-287.

school. Since the county did not have a hospital, Doctors John S. Griffin and Thomas Foster treated approved patients in private boarding houses. The boarding house owners also submitted bills for food, housing, and nursing care to the county.

The 1855 bill was part of the Americanization process in the state. The law required that counties hire “regular graduates” as physicians, thereby endorsing scientific medicine and refusing to legitimize midwives, curanderas, and homeopathic physicians by paying them with state funds. Requiring that prescriptions be submitted in English also reflects efforts to Americanize local governments. These moves show American ascendancy in state government, the application of eastern ideas of social responsibility for the poor, and tensions over the professionalization of medicine that occurred all throughout the country. But, notably, legal scholar Jacobus tenBroek asserts that the 1855 law also represents an adaptation of eastern poor laws to California’s social conditions. Unlike eastern laws, the California statute made no stipulations about residency requirements or family responsibility. Since relatively few American miners came with their families, few men had wives, mothers, or sisters to care for them at home. Nor would these mostly single men have families nearby to pay for their care. And although counties often imposed residency requirements before anyone could receive aid, the law implied that counties who accepted state funding would also be responsible for non-residents. The 1855 statute was attuned to the social and political conditions in California. Lest we forget, single American-born white men voted. This system was primarily designed for them: the miners, laborers, and merchants who fell victim to illness or misfortune.

The arrival of the Daughters of Charity provided an opportunity for the Los Angeles County Board of Supervisors to engage in a more institutionalized approach to its social welfare services. The sisters’ reputation as compassionate, skilled nurses allowed the supervisors to improve health care services and to streamline county financial affairs. Instead of paying several boarding house owners for treatment of the sick, the supervisors would only deal with one institution, and they hoped to better regulate who qualified for services. The benefits of a carry-over of Mexican pueblo government responsibilities for the city’s public health, but American social welfare traditions (and the state legislature) defined relief for the indigent sick as a county responsibility. Therefore, the Common Council did not provide ongoing funding for the sisters’ hospital.

ESTABLISHING SISTERS’ HOSPITAL, 1856-1860

Although the sisters cared for sick patients at the orphanage’s infirmary beginning in 1856, Angelenos continued to encourage Sister Scholastica to expand the sisters’ health services. Sister Scholastica preferred to have the hospital on a separate piece of property, rather than being built on the same lot with the orphanage. By so doing, the sisters could keep their vineyards, a potential revenue source for the institution. Given Sister Scholastica’s position, Bishop Thaddeus Amat and Father Blaise Raho took the issue to the Mayor and Common Council in May 1857. The council then provided an empty lot “for Hospital purposes” on the west side of Adobe Street near the Jewish cemetery. Unfortunately, expected construction costs and its distance from the orphanage dissuaded the sisters from immediately taking possession of the property. However, the city continued to designate the lot as the “Hospital Grounds” and it was used as the “Pest House,” a quarantine facility during small pox epidemics until the 1880s.

The Common Council’s actions in donating land for a hospital represent a carry-over of Mexican pueblo government responsibilities for the city’s public health, but American social welfare traditions (and the state legislature) defined relief for the indigent sick as a county responsibility. Therefore, the Common Council did not provide ongoing funding for the sisters’ hospital.

103 Supervisors John G. Downey, David Lewis, and Stephen C. Foster were appointed as the 1855 Committee of Health, and Drs. John S. Griffin and Thomas Foster attended county patients. “Minutes, 7 July 1855,” Book 1 (1852–1855), 225–226, Historical Board Minutes, Box 1, LACBS, Los Angeles.

104 “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 14 January 1857,” in Daughters of Charity in the City of Angels: Early Writings, 63–64.

105 “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 8 May 1857,” Ibid., 67–68.


107 In 1837, the Mexican Congress gave local government officials responsibility for social welfare issues, including caring for the sick and poor. The legislature charged alcaldes (mayors) and ayuntamientos (town councils) with fostering economic growth, protecting public safety, and building roads and bridges. But, they also assigned pueblos the responsibility of establishing schools, preventing the spread of disease, and managing hospitals and other “public charities” without private endowments. tenBroek, “California’s Welfare Law,” 249–265.
The exact location of the Aguilar Adobe remains unclear. Some accounts list its location on Eternity Street, while others say the adobe was on Spring Street. The notes taken with the Aguilar photo may be a picture of an adobe owned by Aguilar, but it may not be the actual site of the hospital. See Helen Eastman Martin, The History of the Los Angeles County Hospital (1878-1968) and the Los Angeles County–University of Southern California Medical Center (1968-1978) (Los Angeles: University of Southern California Press, 1979), 6–7; “Common Council to Cristobal Aguilar, 4 January 1856,” Los Angeles County Deeds, Book 4, 517, Microfilm Number 2129879, LDS Family History Library, Salt Lake City; “Cristobal Aguilar to Jesus Teran, 5 February 1859,” Los Angeles County Deeds, Book 4, 333, Microfilm Number 2129879, LDS Family History Library, Salt Lake City; “County Hospital Advertisement,” 1859, Ana Begue de Packman Papers, Collection 1491, Box 2, Folder 16, “Hospitals, c. 1850-1860,” UCLA. The county also made additional capital investments in the hospital over the next few months, paying Aguilar $140 in rent and Ozro W. Childs $922.58 for “furnishing material and repairing county hospital.” “Minutes, 4 August 1858,” Book 2 (8 November 1855–16 January 1861), 176, 180, Historical Board Minutes, Box 1, LACBS, Los Angeles. The exact location of the Aguilar Adobe remains unclear. Some accounts list its location on Eternity Street, while others say the adobe was on Spring Street. The notes taken with the accepted picture of the Aguilar Adobe list the address as 658 to 668 N. Spring Street. The picture was taken in 1895, and the notes appear to be written by Ana Begue de Packman, secretary of the Historical Society of Southern California from the 1930s to 1950s. Using deed records, Helen Eastman Martin supports the location on Eternity Street. The Common Council sold Lot 2, Block 32 (Ord’s Survey) to Cristobal Aguilar for $1 on 4 January 1856. Aguilar in turn sold the land to Jesus Teran on 5 February 1859, about three months after the sisters moved to their new location near the orphanage. Martin notes that Aguilar lived in an adobe at 40 Upper Main (now North Spring Street) in 1875, at least according to the LA City Directory. So, this is probably the source of the confusion between the Spring Street and Eternity Street sites. Although difficult to fully confirm, the accepted picture of the

However, the Los Angeles County Board of Supervisors decided to take up the issue. With the promise of some state funding under the 1855 law, they agreed to fund a hospital on a different site than the city had first proposed. In May 1858, the supervisors rented a “house for Hospital purposes” from Cristobal Aguilar located “north of the Church,” and they approved an additional $400 for “fitting up [the] hospital.” The board also agreed to pay the expenses for the hospital’s furnishing and repair. The Sisters’ second hospital was opened on 29 May 1858.

Los Angeles County Hospital may be a picture of an adobe owned by Aguilar, but it may not be the actual site of the hospital. See Helen Eastman Martin, The History of the Los Angeles County Hospital (1878-1968) and the Los Angeles County–University of Southern California Medical Center (1968-1978) (Los Angeles: University of Southern California Press, 1979), 6–7; “Common Council to Cristobal Aguilar, 4 January 1856,” Los Angeles County Deeds, Book 4, 517, Microfilm Number 2129879, LDS Family History Library, Salt Lake City; “Cristobal Aguilar to Jesus Teran, 5 February 1859,” Los Angeles County Deeds, Book 4, 333, Microfilm Number 2129879, LDS Family History Library, Salt Lake City; “County Hospital Advertisement,” 1859, Ana Begue de Packman Papers, Collection 1491, Box 2, Folder 16, “Hospitals, c. 1850-1860,” UCLA. The county also made additional capital investments in the hospital over the next few months, paying Aguilar $140 in rent and Ozro W. Childs $922.58 for “furnishing material and repairing county hospital.” “Minutes, 4 August 1858,” Book 2 (8 November 1855–16 January 1861), 190, Historical Board Minutes, Box 1, LACBS, Los Angeles. The exact location of the Aguilar Adobe remains unclear. Some accounts list its location on Eternity Street, while others say the adobe was on Spring Street. The notes taken with the accepted picture of the Aguilar Adobe list the address as 658 to 668 N. Spring Street. The picture was taken in 1895, and the notes appear to be written by Ana Begue de Packman, secretary of the Historical Society of Southern California from the 1930s to 1950s. Using deed records, Helen Eastman Martin supports the location on Eternity Street. The Common Council sold Lot 2, Block 32 (Ord’s Survey) to Cristobal Aguilar for $1 on 4 January 1856. Aguilar in turn sold the land to Jesus Teran on 5 February 1859, about three months after the sisters moved to their new location near the orphanage. Martin notes that Aguilar lived in an adobe at 40 Upper Main (now North Spring Street) in 1875, at least according to the LA City Directory. So, this is probably the source of the confusion between the Spring Street and Eternity Street sites. Although difficult to fully confirm, the accepted picture of the...
In the midst of the economic instability of the late 1850s and 1860s, the Board of Supervisors had difficulty collecting adequate revenue to meet county expenses. Hence, managing costs at the County Hospital became a constant concern, and a source of tension. In November 1858, the board asserted its right to control admissions to the hospital and refused to pay the expenses of patients not approved by the committee. They officially reasserted these rights in their minutes each year.\textsuperscript{111} By arguing that it had the right to control admissions, the board also limited the efforts of the sisters to provide unconditional charity. Although not bluntly stated in the minutes, the board may also have invoked an implicit definition of the “worthy poor,” those who qualified for county services. Unfortunately, the admissions book from the 1860s has not survived, so it is difficult to specifically determine the parameters the board established.

Although the board’s minutes talk about “the county physician” beginning in 1855, the supervisors did not formally establish a contract system for physicians or pharmacists until 1859. Prior to this time, physicians billed for their services, as did pharmacists. In May 1859, pharmacists submitted proposals for a monthly contract to supply both the needs of the hospital and jail. Physicians bid for a contract to treat sick prisoners at the county jail, a proposal which the board limited to the “average expenditure of the last two years.”\textsuperscript{112} However, the board decided to handle medical attendance at the hospital differently. Following a standard practice of nineteenth-century hospitals, the supervisors approved a plan to rotate the physician-in-charge at the County Hospital. Doctors Thomas J. White, Thomas Foster, and John S. Griffin shared the position of visiting physician and divided the year into three terms.\textsuperscript{113} In the eastern United States, visiting physicians generally donated their services to hospitals in order to build their reputations and attract private patients. Rotating terms allowed physicians to benefit from their connection with the hospital without taking too much time (or money) away from their private practices.\textsuperscript{114}

Yet, the rotation system did not last long in Los Angeles. Foster and White both died by the end of January 1862, leaving Griffin alone to attend to the hospital.\textsuperscript{115} Finally recognizing the hefty demands on his time, the Board of Supervisors agreed to pay Griffin in 1864, offering him fifty dollars per month to act as the county’s physician at the hospital. This fee was in addition to the twenty-five dollars per month that he received for treating sick prisoners at the county jail. The county continued to operate on a contract system until 1876, when the board decided to make the county physician an appointed position.\textsuperscript{116} Even though the Los Angeles Infirmary fit national trends in some ways, it also challenged them. The county paid physicians for their services after 1864, at a time when few institutions paid doctors to attend hospital patients. Nor did most voluntary hospitals allow physicians to collect fees from private patients while residing in the institution.

Opening the Los Angeles Infirmary increased the county’s costs to provide for the indigent sick. The quarterly costs for room, board, and nursing care at the county hospital jumped from $349 in August 1858 to $1029 in May 1859, although the sisters’ costs averaged $723.80 per quarter between 1858 and 1860 (tables 2.1 and 2.2, appendix A).\textsuperscript{117} Board and nursing costs more than doubled after the sisters established the hospital (table 2.3, appendix A). Increased access and improved quality of care likely explain the county’s rising costs, and the sisters’ reputation probably encouraged more patients to seek treatment. In October 1859, El Clamor Público published an account of the history of the Daughters of Charity in an attempt to bolster the hospital’s reputation. The newspaper’s editor, Francisco P. Ramírez, memorialized the Sisters of Charity as fearless, devoted “Angels of Mercy” who ministered to the sick in New Orleans, Baltimore, and St. Louis during the 1832 cholera epidemic: “the faithful Sisters never fell short of their sublime mission, and [even] for just one instant they did not abandon death’s bed. No fear would intimidate them in their solemn and sorrowful duty…. within all the horrors of the suffering humanity, even more terrible than death itself—for them it was a labor of love and religious zeal.”\textsuperscript{118}


\textsuperscript{111} “Minutes, 2 November 1858,” Book 2 (8 November 1855-16 January 1861), 239, Historical Board Minutes, Box 1, LACBS, Los Angeles; “Minutes, 8 November 1859,” \textit{Ibid.}, 295; “Minutes, 21 January 1861,” \textit{Ibid.}, 398.

\textsuperscript{112} “Minutes, 4 May 1859,” \textit{Ibid.}, 265–267.

\textsuperscript{113} \textit{Ibid.}


\textsuperscript{115} Thomas J. White died near the end of December 1861 at the home of his daughter and son-in-law,

\textsuperscript{116} “Minutes, 6 February 1864,” Book 3 (February 1861-October 1867), Historical Board Minutes, Box 2, LACBS, Los Angeles. In 1876, Orme won the appointment with three votes, while James McKee and Dr. Thom received one vote each. “Minutes, 9 February 1876; 3 April 1876,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles. Although Dr. Thom’s first name is not included in the board minutes, it is probably William Alexander Thom, a twenty-three-year-old physician from Virginia who registered to vote in Los Angeles in July 1875. \textit{Great Register of Los Angeles County, 1873-1886}, 113; in California State Library, California History Section, Collection Number: 4-24. CSL Roll Number: 19, FHL Roll Number: 976928. Available at: www.ancestry.com.

\textsuperscript{117} “Minutes, 4 May 1858”; “Minutes, 4 May 1859.”

\textsuperscript{118} …las fieles Hermanas jamás faltaron a su misión sublime, y por un solo instante no abandonaron el
service during the cholera epidemics, Ramirez placed the sisters on a higher spiritual plane, but his article also demonstrated how the venerable history of the order was essential in establishing the credibility of the sisters’ new institution.

By 1860, the Board of Supervisors may have begun to see the full extent of the county’s need for health services. Before the opening of the Los Angeles Infirmary, boarding house operators applied for reimbursement for their charitable activities to care for the sick. Those submitting bills may not have represented all the individuals providing nursing services, nor may they have included the full cost. In contrast, the Los Angeles Infirmary centralized all of the county’s health services into one institution. Private individuals no longer subsidized the county’s costs, and the board felt an increased burden in caring for these patients. Although the supervisors’ records do not disclose the numbers of charity patients supported before the hospital opened, Dr. John S. Griffin reported that 125 were admitted to the County Hospital in 1859. Of these, ninety-eight were discharged, twenty died, and seven remained in the hospital. Twenty-five percent of patients were American, 19 percent Mexican, 12 percent French, 11 percent German, 11 percent Irish, and 6 percent Native Americans. The remaining patients in 1859 were Italian, Russian, and English. The county hospital was open to poor persons of all nationalities, but Griffin noted his concern about the percentage of non-residents using county facilities. Forty-two percent of patients admitted had resided in the county for less than thirty days. Large numbers of non-residents strained county resources, and ran counter to American social welfare traditions that emphasized residency as a qualification for poverty relief. Although the state mandated that counties care for all residents, counties often resented raising taxes to feed, house, and nurse non-residents. In contrast, the Daughters of Charity maintained a spiritual approach to charity, and they strove to support as many poor as their resources allowed.

To meet rising expenses, the county initially responded by increasing taxes. In 1857, the county proposed an assessment of five cents per one hundred dollars of property for the hospital fund. In 1859, only two years later, they proposed to raise the hospital assessment to twenty-five cents per one hundred dollars, thereby increasing the tax by five times to cover the increased expenditures from the hospital. Although the board decreased taxes to seventeen cents per one hundred dollars in 1860, the hospital fund remained $5055 in debt by May 1861. As a result, the county had to pursue other cost-cutting measures.

In the meantime, the state also revised its laws for the indigent sick in 1860. It authorized each county to establish an infirmary, complete with a board of directors and a superintendent. The Infirmary Law also encouraged counties to set up a contract system for physician services, medicine, food, housing, and other supplies. Physicians and pharmacists began bidding on annual contracts to supply services to the hospital and jail by the end of 1859, and the Board of Supervisors decided to switch the sisters to a contract system in January 1861. Instead of billing for the actual costs of care, the sisters were now asked to calculate an average cost per patient per day. Since the sisters took no salary, the rate included food, housing, bedding, other necessary supplies, and the cost of maintaining the facilities. Although the rate may have fluctuated throughout the decade, the sisters received one dollar per patient per day in 1870. Unfortunately, this change may have contributed to the sisters’ financial difficulties. The county listed Sister Scholastica among delinquent tax-payers in May 1861. She owed $98.45 on the sisters’ properties.


Hittell, General Laws of the State of California, paragraph 3771, p. 545.

“Minutes, 10 January 1861,” Book 2 (8 November 1855-16 January 1861), 395-397, Historical Board Minutes, Box 1, LACBS, Los Angeles.

“Hospital Item,” Los Angeles Star, 7 March 1871. Unfortunately, the Board did not record the details of the sisters’ contract during the 1860s. Book 2 contains the Board’s minutes from 10 January 1861, the meeting where the supervisors decided to require the sisters to submit a bid for the hospital contract. The details of the contract are not in Book 2, nor are they recorded in Book 3. The minutes of the board are generally printed in the Los Angeles Star or the Los Angeles Herald, but while these reports contain the substance of the meetings, they rarely report any financial details. The hospital admissions book for the 1860s is also missing, making it impossible to calculate the contract rate by correlating the quarterly costs with the number of patients treated at the hospital.

“Delinquent List of Tax Payers,” Los Angeles Star, 11 May 1861. Although the 1860 Infirmary Law exempted county-owned infirmaries from taxation, the Los Angeles Infirmary was legally a private institution and may not have qualified for the exemption. Since neither the Los Angeles Infirmary nor the Los Angeles Orphan Asylum were officially incorporated until 1869, Sister Scholastica purchased the hospital and seminary properties in her own name, and she would be subject to the same taxes as any other property owner. With the exception of cemeteries, lands owned by religious or benevolent associations were subject to property taxes in the 1860s, so even if the Daughters of Charity had incorporated their institutions earlier, they would have been liable for taxes. The title of the orphanage property remained in the name of the bishop until 1884, although the sisters were given all financial responsibility for the institution. The tax levy published in the paper likely represents the assessments on the seminary and hospital properties, although Bishop Amat may have also given the sisters the tax bill for the orphanage privately. Hittell, General Laws of the State of California, paragraphs 3356, 3779, pp. 487, 546. Deed, John Moran to Honoria Logsdon, 7 August 1858, Los Angeles County
To maintain their autonomy, the Daughters of Charity carefully negotiated a balance between state regulations, county political and economic pressures, and the needs of their patients. The 1860 Infirmary Law authorized boards of directors to “prescribe such rules and regulations as they may think proper for the management and good government of the same, and for introducing the practice of sobriety, morality, and industry, among its inhabitants.” Since the Los Angeles Infirmary did not have an official board of directors, the county’s Board of Supervisors presumed to take this role. On 31 August 1860, Supervisor Abel Stearns proposed a series of resolutions to regulate hospital conditions. The board then ordered that resolutions be printed in the newspaper and disseminated to the wider community. These resolutions required patients to remain in the hospital until officially discharged. They could not “leave the Hospital without permission of the person in charge.”

Neither could patients bring in outside food, liquor, or other items without permission. Visitors had to receive authorization to enter the wards, and “Smoking, spitting on the floor, loud talking, profanity or acts calculated to annoy and disturb the tranquility of the wards [was] strictly prohibited.” While the rules may seem innocuous, they reinforced the cleanliness, order, and moral environment of the hospital.

The 1860 Infirmary Law and its application in Los Angeles suggest the growing influence of eastern models of social welfare practices in California. Whether well-intentioned or not, poorhouse reformers often attached behavioral requirements to public relief. If, as many thought, poverty resulted from individual moral failings, then inculcating moral behavior could, in theory, lift the pauper out of poverty. A state mandate “for introducing the practice of sobriety, morality, and industry” reflected the assumption that the poor lacked self-control. The Infirmary Law also more closely linked county hospitals to the poorhouse model, authorizing superintendents to “require all persons received into the county infirmary to perform such reasonable and moderate labor as may be suited to their ages and bodily strength.” The proceeds of such labor could be applied to reduce the cost of an inmate’s care. This provision reflected the fear that county infirmaries fostered dependence, rather than providing a temporary refuge for recuperation. In reality, few patients could perform any meaningful work, and the county physician immediately discharged those that could. In the end, the 1860 Infirmary Law started to inscribe negative perceptions of the sick poor into the law, concepts that rubbed against the sisters’ philosophy of compassionate respect for those in need.

While the sisters would be unlikely to contest most of the regulations, resolution number five introduced a source of tension that fostered for nearly two decades. Following the prescriptions in the 1860 Infirmary Law, the Board of Supervisors mandated that “Convalescents, when directed, will aid in maintaining cleanliness, and order in the wards and when necessary, assist in nursing.” While the supervisors did not suggest that patients produce goods for sale, it appears that they were starting to view the hospital within the conceptual framework of a poorhouse. The Daughters of Charity consistently avoided working in poorhouses because their religious community opposed institutional philosophies that limited aid to individuals who fit the often arbitrary definitions of the “worthy poor.” These definitions tended to reinforce religious or ethnic bigotry, rather than promoting individual morality and self-reliance. As women who took vows of poverty themselves, the sisters understood the precarious situations many poor families faced and they chose to respond sympathetically rather than with disdain. The religious community’s rules also instructed the sisters to treat all the sick poor with “compassion, gentleness, cordiality, respect, and devotion” as part of their Christian service. In contrast, corrupt poorhouse officials often neglected and mistreated the poor. The Daughters would not have wanted their institutions associated with shameful poorhouse conditions. In Los Angeles, however, the poorhouse model gained political support over the next fifteen years, and the sisters increasingly found themselves at odds with county officials. As will be discussed in chapter four, these philosophical tensions, and the resulting disagreement over the appropriation of financial resources, eventually led to the dissolution of the sisters’ collaborative arrangement with the county in 1878.

In the meantime, the supervisors’ 1860 regulations for County Hospital hinted at some emerging tensions between the sisters, physicians, and the

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125 “Minutes, 31 August 1860,” Book 2 (8 November 1855-16 January 1861), 367-368, Historical Board Minutes, Box 1, LACBS, Los Angeles.

126 “Board of Supervisors: Hospital Regulations,” Los Angeles Star, 8 September 1860.

127 “Minutes, 31 August 1860,” Book 2 (8 November 1855-16 January 1861), 367-368, Historical Board Minutes, Box 1, LACBS, Los Angeles.

128 Ibid.

129 Ibid.

130 Ibid.

131 “Common Rules,” CCD, 13b:151.
supervisors about institutional control. Through these resolutions, the board reinforced the authority of “the person in charge.” But, the resolutions did not define who qualified for that position. The final resolution provided that only the “attending surgeon” could recommend changes to the hospital regulations, thus reinforcing the physician’s influence in the hospital, and male authority in general. Was the county physician “the person in charge,” rather than the sisters? It remained unclear. The board also “ordered that the Clerk of the Board furnish the Superintendent of said hospital with a copy of the foregoing regulations.” This statement suggests that the sisters had limited input in forming the regulations, and that the supervisors sought to reinforce their authority to oversee the hospital.

But at the same time, most of these guidelines were in the sisters’ best interests. Supervising admissions, discharges, and visitors allowed the Daughters to better control the traffic in and out of the hospital. Prohibiting tobacco use and limiting alcohol consumption eased the sisters’ burdens, whether it was merely one less thing to clean or not having to deal with as many unruly patients. And even though they may not have agreed with moving the infirmary towards the poorhouse model, the clause “when directed” gave the sisters the freedom to determine when (and if) a patient worked. In practical terms, the rhetorical tug-of-war over the right to impose regulations made little immediate difference. However, the Daughters of Charity needed to negotiate an autonomous space to effectively balance the relationship between the physicians, politicians, and sister-administrators of the hospital. Public-private collaborations benefited the Daughters because they provided financial resources to assist the sisters in their mission to the poor. Yet, public collaborations came with strings attached, and they required skillful navigation through political waters in order to meet the needs of the sisters, the supervisors, and the needs of the people that they served.

CONCLUSION

Conditions at the Aguilar Adobe were less than ideal for the long-term development of the hospital. Sister Ann Gillen reported that the adobe had four rooms, but “There was not a drop of water on the place, all had to be dipped up at the river, and brought to the Hospital.” The county initially provided ten cots and bedding, and a local butcher and baker provided food for the patients. However, Sister Ann had great difficulty obtaining milk: “It was a stock-raising country and the calves ran with their mothers, and the cows were not accustomed to be milked. O, it was a dangerous operation, I tell you, to milk a cow, for she

had to be thrown down and her feet tied before you could do it!” Sister Ann employed two Native American children to do the cooking and get water for the hospital, and Native American women also washed the laundry. With the adobe’s need for repairs, the lack of water, and their desire to maintain their autonomy, it is easy to understand why the sisters chose to buy property near the orphanage and open a better facility. Yet, despite these challenging frontier conditions, the Daughters of Charity established their reputation as quality caregivers in Los Angeles. The history of the order, and the sisters’ religious identity, enhanced the credibility of the hospital and allowed the institution to expand over time.

Larger facilities eventually allowed the Daughters of Charity to accommodate more patients and to better serve the people of Los Angeles. When the sisters moved to the Alameda Street property in October 1858, Sister Scholastica noted that they had thirteen patients, twelve county patients and one private patient. In 1859, Dr. Griffin reported that 159 county patients and twenty-four private patients were admitted to the hospital. The sisters moved the hospital again in 1860, but they did so in response to the overall needs of their mission, rather than increased demand for hospital services. Since arriving, Bishop Amat had wanted the Daughters to found a number of new establishments, but the high cost of travel made it difficult to send sisters from the east. Local recruitment remained difficult because Californians desiring to become sisters had to be sent to Emmitsburg for training; that was also cost prohibitive. As a result of these challenges and the sectional tensions that threatened to erupt into the Civil War, Father Francis Burlando approved opening a seminary in Los Angeles in November 1860.

Since she had no separate space in which to house young sisters, Sister Scholastica bought new property for the hospital, moved the children’s dormitories into the 1858 Alameda Street hospital, and kept the seminary at the Wilson house. Located on the “road leading to San Gabriel” (later named Naud Street and then San Fernando Street), Sister Scholastica purchased nine acres for $6000 from the executors of Herman C. Cardwell’s estate on 31 January 1861. The Cardwell

132 “Minutes, 31 August 1860.”
The new location offered the promise of more space to house patients, room to build, and further separation of the hospital from the school children. Although financial benefits might also have materialized, spiritual needs motivated the purchase. As directress of the seminary, Sister Scholastica taught young sisters the meaning of religious life. As part of their seminary training, new sisters began apprenticeships in the orphanage school and at the hospital—the methods through which Daughters of Charity accomplished their mission to serve the poor. Immediately, the seminary sisters provided additional staff that would allow the sisters to teach more students and nurse more patients in Los Angeles. But more importantly, Sister Scholastica sought to prepare young sisters to establish new foundations throughout California. Mission remained paramount, and the Daughters used whatever resources were available in their efforts to ameliorate the harsh realities of poverty. Hospital care acted as only one aspect of the sister’s social services. Because the Daughters approached the Los Angeles Infirmary from a social welfare perspective, charitable care remained a priority for the rest of the century. As women, the Daughters of Charity offered a domestic haven for men who had none. As nurses, they provided an almost maternal level of nurturing care for the sick and the dying. As sisters, they provided Catholics with the comforts of a spiritual home, even as the hospital itself became more institutional in its architecture, operations, and to some extent, its character.

Table 2.4 Los Angeles Infirmary Locations, 1858–1884

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1858</td>
<td>Rented Cristobal Aguilar’s four-room adobe “north of the Church.”</td>
</tr>
<tr>
<td>October 1858</td>
<td>Moved into a home purchased from John and Mary Moran adjacent to the orphanage on Macy Street.</td>
</tr>
<tr>
<td>January 1861</td>
<td>Moved into a home purchased from heirs of Herman C. Cardwell located on the road to San Gabriel, later known as Naud Street and then San Fernando Street.</td>
</tr>
<tr>
<td>September 1884</td>
<td>Laid the cornerstone for a three-story hospital in “Beaudry Park,” located one mile north of the Plaza on Sunset Boulevard and Beaudry Avenue.</td>
</tr>
</tbody>
</table>

138 “Mary Scholastica Logsdon, D.C., to Francis Burlando, C.M., 30 December 1860,” in Daughters of Charity in the City of Angels: Early Writings, 99–100.
139 Ibid. Like at the orphanage property on Alameda and Macy Streets, Sister Scholastica may have hoped to use the grapes from the vineyard to produce wine for sale or sacramental use, although there is no surviving evidence that she actually did. She may have sold the grapes to a neighbor, such as Louis Vignes or Matthew Keller, who then used them in their own wine-making facilities. See, “Logsdon to Burlando, 23 June 1857.”
Throughout the last three decades of the nineteenth century, the Daughters of Charity navigated the political and economic challenges of urban growth. When the sisters arrived in the 1850s, Los Angeles was a relatively isolated community of 1,610 people.¹⁴⁰ Ranching and other agricultural pursuits played major roles in the economy and the city had no institutionalized social services. In the early 1860s, drought decimated the cattle industry and curtailed the region’s economic growth, but citrus agriculture, the Inyo silver trade, and increased migration helped to transform Los Angeles from a Mexican pueblo to an American city during the 1870s. The impetus for this growth began when thousands of farmers from the Sacramento and San Joaquin valleys packed up their families and headed south after a month-long rainstorm destroyed their crops in January 1868. Other migrants headed west to escape the war-ravaged South.¹⁴¹ As a result, the population of Los Angeles County grew from an estimated 8,700 in 1866 to 17,400 in 1872.¹⁴² According to the census data, the total number of farms also increased from 306 to 800 during the 1860s. They more than doubled again in the following decade, reaching 1,941 in 1880.¹⁴³ Increased migration and the availability of land produced an economic boom in Los Angeles until California’s financial market crashed in 1875. Newcomers experimented with silk and wool production, sowed corn and barley, and planted orange groves. Merchants supplied the Cerro Gordo


¹⁴¹ Remi A. Nadeau, City-Makers, the Men Who Transformed Los Angeles from Village to Metropolis During the First Great Boom, 1868-1876 (Garden City, N.Y.: Doubleday, 1948), 8-15.


Along with increased migration, diversifying the economy introduced new players into Los Angeles politics—voters, businessmen, and politicians who had no memory of the pueblo’s frontier past and few ties to the Spanish-Mexican rancheros who had dominated its society. They did not know (or perhaps, even care) about how the Daughters of Charity had improved the city’s health services during the prior decade. These boosters had their eyes focused on the future, on what the city could become. By 1872, Angelenos installed gas street lamps, laid water pipes for residential and agricultural use, imported a steam-powered fire engine, and founded two banks.145 Designed to eradicate their frontier image as “Queen of the Cow Counties,” these measures illustrated the city’s fitness for business investment, including becoming the southwestern terminus for the Southern Pacific Railroad in 1876. Importantly, boosters’ image of the city also included “up-to-date” public health and medical services.

Although it would mature in subsequent decades, health boosterism emerged as a strategy to promote the economic growth of Los Angeles in the 1870s. Between 1870 and 1900, medical climatologists, physicians, and former health-seekers actively promoted Southern California’s sunshine, dry air, and cool nights as potential life-savers for individuals suffering from all types of health complaints, particularly pulmonary disease. As historian John E. Baur explains, the “health quest” became a mainstay for real-estate promoters, development companies, newspapers, railroads, and hotels—directly or indirectly affecting the influx of invalid and healthy newcomers to the region.146 Health-seekers, those migrants who moved to Los Angeles in hopes that the climate would alleviate chronic illness, also required physicians to treat them. The “health legend” signified economic opportunity for doctors who wished to come west. A considerable number of physicians lived in Los Angeles in the 1870s, and city directories list the doctor to patient ratios as being anywhere from 1 to 146 to 1 to 400.147 To succeed in an increasingly competitive market, a physician had to increase his public visibility, build an impeccable professional reputation, and attract a steady stream of private patients. Physicians like Joseph P. Widney and Walter Lindley did this by making forays into civic organizations, local politics, and real estate. For example, Widney served on the Board of Education in 1873 and lobbied for the development of a harbor in Los Angeles. By doing so, Widney extended his personal and professional networks, thereby enlarging

144 Nadeau, City-Makers, 14-19, 42-43.

145 Ibid., 6, 47-52.


his potential pool of private patients.\textsuperscript{148} Besides increasing his visibility, business or real estate investments could also provide a physician with additional income if medicine did not quite pay all of his bills. Successful physicians inserted themselves into prominent positions in the community and wielded economic and political influence in matters that extended beyond medicine.

Yet most doctors retained medicine as their primary means of support, and physicians organized to promote their professional interests. Founded in 1871, the Los Angeles County Medical Association (LACMA) sought “the promotion of the character, interests, and honor of the fraternity by maintaining the union and harmony of the regular profession of the county, and aiming to elevate the standard of the medical education.”\textsuperscript{149} The association investigated practitioners’ credentials, set a standard schedule of fees to prevent unfair competition, and sought to assert its authority in matters of public health. Although they did not accomplish this goal immediately, LACMA members also endorsed the prospect of founding a medical school in the city, a venture which would require hospital access for students’ clinical training. To regulate the boundaries of their profession, ensure its profitability, and set acceptable standards of care, physicians cultivated a level of professional authority through which they attempted to exert power over nurses, hospitals, and community officials responsible for public health. Physicians’ organization, as well as their involvement in politics, business, and real estate, made them a powerful interest group in the development of Los Angeles, especially as health boosterism was seen as a major asset for the city.

\textsuperscript{148} Dr. Joseph P. Widney also participated in the city’s booster efforts as a proponent of improvements for the San Pedro harbor. In 1871, Widney was one of the founding members of the Los Angeles County Medical Association, he served on the Board of Education in 1873, and he was appointed county physician in 1874. Marco R. Newmark, “Two Community Builders of Los Angeles,” \textit{Southern California Quarterly} (1951): 136-144; Carl Wheeler Rand,\textit{ Joseph Pomeroy Widney: Physician and Mystic}, ed. Doris Sanders (Los Angeles: Anderson, Ritchie, and Simon, 1970), 26-30, 65-66. Dr. Walter Lindley arrived in Los Angeles in 1875. He needed to make a name for himself, which he did by becoming president of the first Young Mens’ Republican Club in 1877, opening the Los Angeles Free Dispensary during the same year, and becoming secretary of LACMA in 1878. Harnagel, “The Life and Times of Walter Lindley, M.D.,” 307-308.

\textsuperscript{149} “Constitution and By-Laws of the Los Angeles County Medical Association, Record, L.A. County Medical Association, 1871-1891,” 3, Los Angeles County Medical Association Collection, Huntington Library, San Marino, CA. LACMA’s founding members (John S. Griffin, Russell T. Hayes, J.P. Widney, William F. Edgar, Henry S. Orme, T.H. Rose, and Levi L. Dorr), were all men, but the “fraternity” of medical men eventually included five women: Rose Talbot Bullard, Lula Talbot Ellis, Elizabeth Follansbee, Alice Higgins, and I.M. Meader. The Talbot sisters were also married to physicians who belonged to LACMA. LACMA Membership lists and “Minutes, 31 January 1871. Record, L.A. County Medical Association, 1871-1891,” Los Angeles County Medical Association Collection, Huntington Library, San Marino, CA.

The consequences of urban growth and the professionalization of medicine profoundly affected the Daughters of Charity in Los Angeles during the 1870s. Not all of the newcomers to Los Angeles were healthy, wealthy, or fiscally wise, and many sick migrants found their way to the sisters’ hospital. New medical institutions also emerged, ending the sisters’ monopoly in hospital care. Immigrant mutual aid societies opened hospitals for their members during the decade, thereby introducing economic competition into the market, especially among those patients who could afford to pay for their treatment. At the same time, tight county budgets constrained the sisters’ efforts to move beyond convalescent care, and boosters promoted the establishment of a new facility that included modern features, economized with efficiency, and provided opportunities to advance medical education. The Daughters adapted to these changing conditions, negotiated the political minefield to the best of their ability, and continued to be advocates for quality health care for the poor.

\textbf{THE “BOOM YEARS” AT THE LOS ANGELES INFIRMARY}

Demonstrating the public-private character of the Los Angeles Infirmary, the Daughters of Charity continued to care for paying patients and the county’s charity patients throughout the 1860s. As the city grew and the county continued to pressure the sisters to reduce their costs, the Daughters expanded their facility to accommodate more private patients. Beginning in 1869, the sisters advertised the addition of private rooms for both male and female patients: “The Sisters of Charity would respectfully announce to the suffering members of the community, that, having completed a large, commodious, well-ventilated Building for the use of the County Patients, they can now accommodate a number of both male and female patients with PRIVATE ROOMS, where they can receive the care and attentive solicitude of the devoted Sisters.”\textsuperscript{150} In tone, the advertisement reflects the humility of the sisters, but it also stresses the quality of their facilities and the devotion of the sister-nurses. Advertising a “large, commodious, well-ventilated Building” also illustrates the understandings of health care at the time.\textsuperscript{151} Following Florence Nightingale’s \textit{Notes on Hospitals} (1863), reformers maintained that overcrowding and poor ventilation increased the spread of hospital-born diseases.\textsuperscript{152} Although the two-story home which

\textsuperscript{150} “Los Angeles Infirmary Advertisement,” \textit{Los Angeles Star}, 29 May 1869.

\textsuperscript{151} Ibid.

\textsuperscript{152} Florence Nightingale, \textit{Notes on Hospitals} (London, U.K.: Longman, Green, Longman, Roberts, and Green, 1863), 6-7. Florence Nightingale proposed changes to hospital architecture to limit the spread of hospital-born diseases. She claimed that overcrowding, poor ventilation, and poor sanitation
The Ann Street Hospital, c. 1880.

Purchased in 1861, the sisters moved the hospital to property “on the road to San Gabriel,” later known as Naud Street, San Fernando Road, and Ann Street. They remained here until 1885.

Courtesy St. Vincent’s Medical Center Historical Conservancy, Los Angeles

housed the hospital did not reflect Nightingale’s “pavilion plan,” the Daughters stressed that their facility had all the essentials necessary for a healthy recovery.

In addition, a private room further isolated an individual from other patients, satisfying both perceived medical and social needs. Charles Rosenberg notes that private patients often received better food and accommodations than free patients, and private rooms spared middle-class and wealthy patients from “unpleasant associations” in the charity ward. Class separation would be particularly important in treating female patients, for many “respectable” women would be reluctant to endure the indignities of an open ward surrounded by strange, dirty, morally questionable men. By announcing private rooms for female patients, the Daughters increased infections and mortality rates. Believing these infections were preventable, she proposed building hospitals on the “pavilion plan.” To prevent the spread of disease, Nightingale advised that hospital wards, or pavilions, should be constructed as one-story wooden structures with long hallways, easily ventilated by cross-breezes from doors or windows at either end. Patients should be allotted a certain amount of cubic space to prevent overcrowding, one bed per patient.

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Millenry and domestic work were among the more typically female occupations. As for ethnicity, Americans and Irish made up the two largest groups, 30 percent and 26 percent respectively (table 3.2, Appendix A). 158 According to the 1870 census, approximately 72 percent of Los Angeles county residents were “native-born persons,” so it makes sense that Americans formed the largest ethnic group. But the census also reports that Irish immigrants only comprised 3 percent of the county’s population, so the Irish may have been disproportionately represented among the sick poor (or highly mobile and underreported in the census). 159 Only 3 percent of patients were born in Mexico. At first glance, this statistic seems surprising because of the large numbers of Mexican Catholics, and the growing poverty among the Mexican population in Los Angeles. However, the patients of Mexican descent may have been underrepresented since Californio-Mexicans were born in the United States and not identified separately. Nor were Native Americans identified as a separate group. So, while it is tempting to argue that the county discriminated against Mexicans by denying them medical care, there is not enough evidence to justify this supposition. Nevertheless, the predominance of Irish immigrants among hospital patients deserves further evaluation.

Ethnicity, religion, and class played a role in an individual’s decision about where and when to seek hospital care. Since, throughout the country, hospitals sought to provide a “home-like” environment for their patients, shared understandings of language, culture, and religion added an extra measure of comfort for these sick, lonely men isolated from their families. As a charity hospital, class remained the most significant factor in a patient’s decision to be treated at the Los Angeles Infirmary, but ethnic and religious identities also played a role—particularly for private patients. French or German Catholics could choose to be treated at hospitals operated by the ethnic benevolent societies, but Irish Catholics tended to go to the Los Angeles Infirmary where they could be treated by their own countrywomen. 160 According to the 1870 census, five of the seven sisters who worked at the hospital were born in Ireland. The remaining two sisters were from Massachusetts and New York, and they may have been Irish American. 161 In 1876, the sister in charge of admissions was probably Irish as she identified Irish patients by their county of origin, not just the country. Besides demonstrating the continuing importance of local identity to Irish immigrants, this trend also suggests a sense of familiarity and connection with the sisters. Most Irish patients were charity cases, but 26 percent of the Irish men and women treated at the hospital were private patients. Those who could pay still chose the sisters’ care, further illustrating the importance of religious and ethnic identity in nineteenth-century hospitals.

As the economic boom continued in Los Angeles, the Daughters of Charity sought to expand their services to better meet the needs of the growing city. In February 1870, the sisters purchased a lot near St. Vincent’s College “to erect a more suitable Hospital on a modern plan.” 162 They purchased 4.55 acres for $3000 from Ozro W. Childs, A.B. Chapman, and Andrew Glassell, business partners and trustees of Farmers and Merchants Bank. However, their neighbor William Moore disputed the sisters’ title in 1872, claiming that he bought the property from the city in 1859. Moore lost the case, since the city did not record his purchase, and he failed to dispute the title when Childs bought the land in 1864. Although Moore’s loss seemed to assure the sisters control of the property, another neighbor, Florida Nichols, filed a similar suit in 1875. 163

158 Ibid.
159 “1870 Census, California. Historical Census Browser” (University of Virginia, Geospatial and Statistical Data Center), online: http://fisher.lib.virginia.edu/collections/stats/histcensus/index.html (accessed 18 October 2012).
160 In their publicity, neither the French nor the German Benevolent societies made any reference to religion, so they were probably open to both Protestants and Catholics. According to Helene Dujardin-Demeestere, the French Hospital was open to members of the society under age fifty, who were in good health, and could afford to pay the society’s monthly dues. Helene Dujardin-Demeestere, dissertation in progress re: French immigrants in nineteenth-century Los Angeles (Université de Paris I, Panthéon-Sorbonne). Demeestere’s dissertation builds on her master’s thesis about the French Benevolent Society. Helene Dujardin-Demeestere, “La Société Française De Bienfaisance Mutuelle De Los Angeles Est Elle Bien Le Reflet De La Population Française De Los Angeles” (Université de Paris VIII, St. Denis, France, 2007). I have not been able confirm the religious affiliation of the French Benevolent Society’s doctor, S.H. Nadeau, so it is unknown to what extent his religion may have factored into a patient’s decision to seek treatment at the French Hospital. However, the German Benevolent Society’s doctor, Joseph Kurtz may have been Catholic, since his daughter Christine married John A. McGarry in the Plaza Church on 26 June 1901. John’s parents, Daniel M. and Margaret McGrar- ry, led a prominent Irish Catholic family who supported fundraisers for the Daughters of Charity’s orphanage in the 1890s. John Steven McGroarty, Los Angeles: From the Mountains to the Sea, vol. 3 (Chicago: American Historical Society, 1921), 636; James Miller Guinn, A History of California and an Extended History of Los Angeles and Environs: Also Containing Biographies of Well-known Citizens of the Past and Present (Historic Record Company, 1915), 99-100; “The Orphan’s Fair An Unqualified Success,” 1890, Maryvale Historical Collection, Newsclipping in Maryvale Scrapbook 2, Box 4, Folder 14, Maryvale, Rosemead, CA.
161 U.S. Census, Los Angeles, 1870. The 1870 census lists Sister Ann Gillen as being born in Ireland, but both the 1860 and 1880 census lists her birthplace as Ohio, although the 1880 census notes that her parents were born in Ireland.
162 “Minutes, 4 April 1870,” Corporation Book, 1869-1909, SVMCHC, Los Angeles.
163 The sisters purchased 4.55 acres in block number 22 ½, between Sixth and Seventh streets, near Grasshopper and Flores. Presumably, the sisters sought to move into the city to be closer to St. Vincent’s College and more accessible to patrons. See “Case 1961. William Moore Vs. Los Angeles Infirmary,” 1872, Los Angeles Area Court Records, California 17th/1st District Court, Civil Cases, Box 72, #1961-1971, Huntington Library, San Marino, CA; “Case 2679. Florida Nichols Vs. Los Angeles Infirmary,” 1875, Los Angeles Area Court Records, California 17th/1st District Court, Civil Cases, Box 103, #2646-2658, 2660-2681, Ibid. Incidentally, William Moore was the county surveyor.
Nichols again lost the case, but such legal action suggests that neighbors resisted efforts to build a hospital next to their land. Angelenos were willing to extend some charitable support for the suffering and sick, but the recipients of that aid remained tainted with the suspicion of being “lazy tramps.” Few Angelenos wanted a hospital in their backyard, nor did they want to pay “too much” to aid the so-called “unworthy poor.” Moore and Nichols likely feared exposure to disease, an increase in unsavory patrons hanging around the neighborhood, and a potential loss of property value if the hospital was built next door.

Frustrated, the sisters decided to stop their efforts to build on the property. In April 1875, Childs agreed to refund the sisters’ money with interest, if they deeded the land back to him. The sisters had already purchased another fifteen acres of land on Pico Street. Unfortunately the 1876 financial panic made it difficult to acquire loans or donations to fund construction, and the sisters decided to build a new ward for county patients on the Cardwell property where the hospital had resided since 1861. However, the Southern Pacific built a new depot across the street from the hospital on San Fernando Road in 1875, and the company planned to transfer all freight and passenger operations there by the spring of 1877. The noise from the freight yards and machine shop would disturb the peaceful setting the sisters cultivated for their patients on what was then the “outskirts of town.” Historians Larry Mullaly and Bruce Petty note that the depot also brought “its own ambience of railroad-oriented saloons and boarding houses.” By the early 1880s, San Fernando Road was hardly the environment the sisters envisioned for themselves and their charges.

GENDER, STATE AID, AND THE DOWNSIDE OF THE BOOM, 1868–1870

Despite the emerging economic prosperity of the early 1870s, local officials increasingly worried about the effects of increased immigration on the county’s social welfare system. As Wallace Woodworth, the chairman of the Board of Supervisors explained, “the hardships and exposures undergone by those who sought to develop the mineral wealth of the Pacific, has undermined and broken down the health of a large number of vigorous men, who are daily turning their feeble steps to

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165 “Minutes, 4 January 1875, 1 July 1878,” Ibid.
166 “Minutes, 3 January 1876, 2 October 1876,” Ibid.
the counties of the South, in hopes of either recovering their health or protracting for a time their lives.” Arriving “penniless and suffering,” these men filled the beds of the Los Angeles Infirmary, reigniting a discussion of the county’s responsibility for the poor. By 1876, worsening economic conditions further magnified the problem, increasing public attention and criticism upon the Daughters of Charity.

The economic boom dramatically increased health care costs in Los Angeles County. Between 1868 and 1869, county costs for the indigent sick doubled from $4684 to $9195. This did not include the city government’s expenses during the 1869 smallpox epidemic. Woodworth reported that city and county health care costs totaled $18,437.81 during 1869, “a sum of money almost equal to the total civil expenditures of the county.” He believed that the state should cover these increased costs, since two-thirds of patients treated at the county hospital were not county residents. He hoped the legislature “would be unwilling to permit this county to bear all the burden of relieving and maintaining the unfortunates from every part of the State and the adjoining Territories.” Woodworth praised the Daughters of Charity and their “well-managed” hospital, but he petitioned for state aid because the migrants were overwhelming county resources. He hoped the legislature “would be unwilling to permit this county to bear all the burden of relieving and maintaining the unfortunates from every part of the State and the adjoining Territories.”

Woodworth asserted that the state had a responsibility to care for immigrants, not the county. In so doing, he mirrored arguments by other social institutions in San Francisco. In 1870, both the Ladies’ Protection and Relief Society (LPRS) and the San Francisco Lying-In Hospital justified their request for appropriations because they acted as state institutions. The LPRS operated a home for destitute women and children who migrated from the interior mining regions of the state, hoping to make a new start in San Francisco. The Lying-In Hospital also accepted women from all parts of the state, who fled from difficult situations without the necessary resources to care for their newborn children. Its Board of Managers frankly argued that the Lying-In Hospital was “a State institution, opening its doors, freely and without discrimination, to persons from all parts of the State.” Both institutions claimed that they did not discriminate by nationality, class, or religion. By being open to all residents—whether out of compassion or policy—these private social institutions felt justified in asking all classes of citizens throughout the state to support their institution with tax dollars.

An anti-discriminatory stance on social welfare issues seems somewhat out of place, especially considering the growing racial cleavages within the state during the 1870s. Historian Tomás Almaguer demonstrates that the tenets of Manifest Destiny and free labor ideology supported a process of racialization that placed Mexicans, Native Americans, and Asians in a subordinate place to European-American men. In turn, racialization “largely structured their access to material means and social status.” Mexican rancheros lost land, wealth, and political influence, while government-sponsored programs decimated Native American populations. Labor unions also fashioned Chinese immigrants as threats to white workers, pressuring the state to establish restrictionist policies that culminated with the Chinese Exclusion Act in 1882. In 1870, the legislature required ship captains to certify that Chinese men and women immigrated voluntarily and were “person[s] of correct habits and good character.” Intended to halt the spread of prostitution and coolie “slave” labor, the acts also illustrate an increasingly racialized construction of immorality and crime. In the same session, the legislature extended annual subsidies for orphans, established a state board of health, and appropriated a total of $66,000 for charitable institutions throughout the state. The frequency with which private charities based petitions for aid on their non-discriminatory policies suggests that they perceived open access as a qualification for state funding. It also suggests a more inclusive view of the polity, at least concerning social welfare issues. In theory, poor men, women, and children deserved humanitarian,

According to Michael Omi and Howard Winant, social, economic, and political factors shape “the content and importance of racial categories,” and racialization is a historical and ideological process which “specifies the extension of racial meaning to a previously unclassified relationship, social practice or group.” Michael Omi and Howard Winant, Racial Formation in the United States: From the 1960s to the 1990s, 2nd ed. (New York: Routledge, 1994), 62-63, 64. Tomás Almaguer, Racial Fault Lines, 12-16, quote on 205.


“An Act Appropriating Money for the Support of the Several Charitable Institutions Therein Specified, During the Twenty-second and Twenty-third Fiscal Years, Commencing on the First Day of July Eighteen Hundred and Seventy, and Ending on the Thirtieth Day of June, Eighteen Hundred and Seventy Two, Inclusive”; and “An Act to Establish a State Board of Health,” in ibid., 329-330.

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169 “Petition of the Board of Supervisors for an Appropriation for the Support of the Non-resident Sick of Los Angeles County,” in Appendix to Journals of Senate and Assembly of the 18th Session of the Legislature of the State of California, 1870, Volume 3 (Sacramento: D.W. Gelwicks, State Printer, 1870), 5. Note: each report in the appendix is individually paginated.

170 Ibid.

171 Ibid.

172 “Petition of the Trustees of the San Francisco Lying-In Hospital and Foundling Asylum for State Aid,” in Ibid., 5.
charitable aid regardless of race or religion. And importantly, the managers of charitable institutions believed that state government had a responsibility to provide for those who did not, strictly speaking, belong to the local community.

These trends illustrate the interplay between public and private responsibility for social provision, and reformers’ growing reliance on state intervention before the Progressive Era. Gender also significantly shaped city and state actions regarding poor relief. As historian Mary Ann Irwin claims, gender influenced San Francisco’s response to social welfare issues between 1850 and 1880. Women-led charities organized on behalf of poor women and children, blended traditions of Christian charity, femininity, and domesticity. Irwin claims that women-led charities garnered support from businessmen, workers, and city officials because they kept taxes low, voters happy, and provided a bulwark against “the corruption that seemed inevitably to follow expansion of the public sector.”177 Gender also shaped the legislature’s response to social welfare issues in 1870. Of the sixteen benevolent societies that received state appropriations in 1870, all had significant levels of leadership by women. With the exception of the Los Angeles Infirmary, the California Prison Commission, and the Home for the Care of the Inebriate of the City of San Francisco, the organizations all operated institutions for poor women and children. Seen as dependents outside the body politic, the state could bestow charitable gifts for women and children regardless of race or religion without endangering white male dominance.

However, when Los Angeles officials asked for state support for indigent adult men, its were ignored. Many suspected hospital patients of being “tramps,” lazy, able-bodied men in search of a warm meal and roof over their heads. While they could justify aid for defenseless children, legislators were much more reluctant to underwrite adult dependence during the 1870s. In addition, legislators may not have wanted to set a precedent that the state would be responsible for non-resident health care during smallpox epidemics, particularly in light of the 1869-1870 epidemic which had spread throughout the state. If the legislature gave money to Los Angeles to alleviate unusually high health care costs, it would also have to give money to nearly every other county in the state.178 Los Angeles supervisors repeatedly applied for state aid to reduce health care costs during the decade, and the legislature repeatedly denied their petitions.

Interestingly, the legislature did appropriate $1000 for the sisters’ hospital in Los Angeles, even as it rejected the county’s claims in 1870.179 The legislature recognized the need of the hospital, but it did not want to give aid directly to the Board of Supervisors. Why? First, assigning the appropriation to the sisters did not admit the state’s responsibility to provide for the county’s indigent sick. Second, the appropriation went directly to the sisters, and thereby avoided getting caught up in county politics. When they appropriated money for the hospital as a benevolent institution, state legislators also recognized the sisters’ status as a private corporation, albeit one that promoted the public’s general welfare.180 The appropriation itself, $500 per year in 1871 and 1872, was small, but nevertheless welcome. Finally, giving money to the sisters fit within the gendered framework of other charitable appropriations. As a woman-led institution, the Los Angeles Infirmary reinforced traditional conceptions of privately-sponsored Christian charity, even though the hospital and other women-led charities received public money.

**PROFESSIONALIZING MEDICINE IN LOS ANGELES**

In the 1870s, doctors began performing more complicated procedures at the Los Angeles Infirmary even without a proper operating room, thus setting the institution on a path towards modernization. On 20 March 1871, Doctors William F. Edgar and N.P. Richardson performed an operation on John Searles at the county hospital, assisted by dental surgeon J.S. Crawford. Searles had been attacked by a grizzly bear in the mountains east of La Liebre Rancho the week before and his lower jaw bone was fractured in two places, so severely that the muscles prevented the bone from being set in its proper position. The doctors “found it necessary to perforate the ends of the bones and bind them together with silver wire” to keep them in contact so the bones could heal. The Los Angeles Star reported, “Mr. Searles lies in a very critical condition, and but faint hopes are entertained of his recovery by the attendant physicians, although we understand that he himself is in good spirits, and confident of


178 Smallpox epidemics remained highly racialized in the late nineteenth century, and in San Francisco, Chinese immigrants were blamed for spreading the disease. If politically undesirable immigrants were deemed responsible for an outbreak, it was unlikely there would be much legislative support to extend state aid for smallpox victims, even in faraway places like Los Angeles. See Nayan Shah, Contagious Divides: Epidemics and Race in San Francisco’s Chinatown (Berkeley: University of California Press, 2001), 57-63.

179 “An Act Appropriating Money,” 77-78.

180 The legislature also renewed its support for the sister’s hospital, appropriating $1500 in 1873, and $2,000 in 1875. However, the appropriations were made for the “Sisters of Mercy Hospital of Los Angeles.” The Sisters of Mercy operated a hospital in San Francisco, but they did not have any sisters in Los Angeles in the 1870s. The Sisters of Charity were the only Catholic sisters living there during the 1870s. Despite the confusion of the community’s name, the appropriations must have been for the Los Angeles Infirmary. “An Act Making Appropriations for Benevolent Purposes,” in Statutes of California Passed at the 20th Session of the Legislature, 1873-1874 (Sacramento: G.H. Springer, State Printer, 1874), 897-898; “An Act Making Appropriations for Benevolent Purposes,” in Statutes of California Passed at the 21st Session of the Legislature, 1875-1876 (Sacramento: State Printing Office, 1876), 828.
revisiting his old hunting ground, and again paying his respects to the bear.”

Even in 1870s Los Angeles, physicians started to see hospitals as places for scientific advancement, the development of new procedures, and strengthening one’s professional reputation. However, Los Angeles only had two hospitals by 1875: the sisters’ Los Angeles Infirmary and the French Hospital founded in 1869. As more physicians moved to the city and began to exert some political influence through the Los Angeles County Medical Association, they also began vying for more influence in hospital affairs. The Daughters of Charity had to negotiate with both physicians and county politicians to provide adequate patient care and to keep control of their facility.

The professionalization of medicine after the Civil War started to shift the balance of power between physicians and skilled, but non-professional sister-nurses and sister-administrators within Catholic hospitals throughout the United States. Before 1870, Catholic sisters’ commitment to religious charity, their unpaid labor, and the community’s system of apprenticeship made it possible to provide health care for the indigent sick at low costs. However, physicians increasingly constructed medicine as an elite profession with considerable cultural authority. Physicians based this authority on more rigorous medical education, clinical experience, licensing, and the increased use of scientific medical procedures. As scientific medicine became more trusted, patients started to expect physicians to cure disease, and physicians started to use hospitals to dispense acute specialized treatment, rather than to house convalescents.

In addition to regulating medical practitioners, physicians sought to consolidate their power over other aspects of American healthcare, including hospital administration and nurses’ training. In Daughters of Charity hospitals, provincial leaders tended to assign sister servants (local superiors) as hospital administrators, thereby conflating religious and occupational authority. While sister-nurses sought to maintain collegial relationships with physicians, their first duty was obedience to God and their superiors. Physicians stood outside this line of authority, and as Martha Libster and Betty Ann McNeil, D.C., attest, doctors found themselves in a difficult situation, “in that they really needed the skills and assistance of those women who could not and would not be under their complete control.” Turf wars between doctors, nurses, and administrators developed in hospitals throughout the country, but they could become particularly strident at religious institutions where participants had to balance scientific and religious authority. From the physicians’ perspective, one potential solution to these challenges was to train more submissive nurses, those who would accept physicians’ purported professional superiority. Properly trained nurses would follow doctors’ “orders” rather than collaborating with physicians on curative measures to promote a patient’s overall well-being. In contrast, Libster and McNeil maintain that sister-nurses exercised a great deal of autonomy in ministering to the needs of patients, acting in concert with the advice and suggestions of physicians. They also “exercised their own judgment to intervene on behalf of patients” if needed. Not all physicians were willing to give nurses this kind of authority, fearing that it would undermine their professional position. In an effort to secure legitimacy for their field, secular nursing leaders also aligned themselves with scientific medicine after the Civil War, conceding to physicians’ dominance in a clinical setting in exchange for their support of nursing as a profession. Traditionalists, such as the Daughters of Charity, tended to be labeled as “unprofessional,” thereby reinforcing the importance of the new training system.

In her study of the Sisters of Charity Hospital in Buffalo, New York, historian Jean Richardson asserts that the professionalization of nursing and the modernization of medicine threatened to undermine not only the sisters’ authority as nurses, but also as hospital administrators. Instead of cooperating with physicians as relative equals, Richardson explains, “The new theories threatened to overthrow the sisters’ autonomy by vesting monopoly control over medical affairs in the physicians. The impact upon Sisters Hospital of this new superordinate-subordinate relationship could make the sisters servants in the hospital they owned and administered.” Catholic sisters often got caught in power struggles within the medical community because the connections between doctors, patients, and medical schools affected a hospital’s bottom line. Richardson notes that, doctors became relatively more important in hospitals as government subsidies and philanthropic contributions dwindled in the 1870s. Hospitals started to depend more on patient income, and they also needed the cheap student labor of medical school interns, residents, and nursing students. In addition, the sisters needed to maintain the hospital’s financial stability to continue their mission of spiritually-oriented patient care. Sister-administrators engaged in a delicate balancing

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181 “Surgical Operation,” Los Angeles Star, 21 March 1871.
182 Directory of Los Angeles for 1875, 84.
183 Libster and McNeil, Enlightened Charity, 326.
184 Ibid., 136.
185 Ibid., 250. See also 218, 249, 326.
186 Richardson, A History of the Sisters of Charity Hospital, Buffalo, 129.
187 Ibid., 107-120.
act to maintain good relationships with physicians and meet the community’s changing expectations of medical services, containing physicians’ professional aspirations while maintaining the sisters’ authority and autonomy in the hospital. Sisters often risked great financial losses to maintain their autonomy, prioritizing their mission and retaining the distinctive character of their institutions.

As the only publicly-funded medical institution in the region, the Los Angeles Infirmary acted as the most visible symbol of the medical profession in southern California, and members of the Los Angeles County Medical Association (LACMA) became increasingly interested in its practices. One month after the association was organized, its officers asserted their interest in hospital affairs. Dr. Russell T. Hayes, LACMA Vice President, and Dr. Henry S. Orme, the LACMA Treasurer, successfully bid for the position of county physician for 1871 and 1872.188 By seeking the position, LACMA officers affirmed that the hospital mattered to the medical community and that the association’s standards would be upheld there. The new county physicians probably encouraged Doctors Edgar and Richardson to perform surgery in the hospital after the bear attack on Searles, thereby expanding the scope of the institution’s services. By accepting the position, LACMA officers also inserted themselves into county politics. Orme and Hayes would now be in an official position to influence hospital policies and conditions. Importantly, these maneuvers were made with the funding agency, and not the sisters themselves, thereby maintaining the “fraternity” of political and professional connections that strengthened physicians’ authority in the community.189

Throughout the rest of the decade, LACMA continued in its efforts to regulate conditions—particularly the actions of physicians—at the sisters’ hospital. Between 1871 and 1876, the Board of Supervisors maintained a practice of accepting the lowest bidder for county contracts, including the contract for medical attendance for county-supported patients treated at the sisters’ hospital. Ambitious physicians K.D. Wise and Samuel W. Brooke deeply undercut the other physicians’ bids to obtain the contract in 1873 and 1875, respectively. In 1873, Wise bid 28 percent less than the contract rate for the previous year, charging the supervisors only thirty dollars per month to attend patients at the hospital and jail.190 By doing so, he ousted established physicians Orme and Hayes from the job. However, Wise’s performance was apparently unsatisfactory. At the end of the year, patients filed a petition with the board and the supervisors established a committee to draft new rules for the hospital. Although the contents of the patients’ petition were not entered into the board’s minutes, it likely detailed grievances against Dr. Wise as the supervisors failed to renew his contract the following day. The board then elected Joseph P. Widney as county physician and raised his salary to $100 per month, more than triple Wise’s salary. Widney then participated with board members George Hinds, Edward Evey, and Francisco Palomares to draft new policies for the hospital. The committee included the requirement that “The physician in charge shall visit the hospital once each day,” presumably a response to Dr. Wise’s neglect of his responsibilities at the institution. The board also raised the county physician’s salary to induce reputable physicians to invest their time at the hospital.191

Widney, a founding member and later president of LACMA, used this opportunity to restore confidence in his profession. But, the board’s new guidelines clearly reinforced the power of the county physician within the hospital in requiring him to approve the admission of all patients, the purchase of supplies, and the submission of all bills to the county. Widney also tried to improve record-keeping practices at the hospital. He suggested that the county print individual admission forms, but the supervisors refused his proposal, opting for pre-printed (and probably reusable) tickets as proof of county approval for a patient’s admission to the facility.192 These actions required physicians to spend more time and energy supervising the institution, giving them administrative as well as clinical responsibilities. The rules also suggest that the board lacked confidence in the abilities of the Daughters of Charity to manage the hospital’s financial affairs, either because they did not hold adequate professional authority as compared to physicians, or because the supervisors


189 “Constitution and By-Laws of the Los Angeles County Medical Association, Record, LACMA, 1871-1891.”

190 Orme and Hayes charged the county $499 per year in 1871 and 1872, but Wise submitted a bid of $360 which, as the lowest bid, was accepted. “Minutes, 6 March 1871.” “Minutes, 7 April 1873; 8 April 1873,” Book 5 (6 June 1871-July 1873), Historical Board Minutes, Box 3, LACBS, Los Angeles.

191 “Minutes, 6 April 1874; 7 April 1874; 8 April 1874,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles. Wise apparently continued to act unscrupulously in his medical practice in Los Angeles, since LACMA blacklisted him in 1878, and threatened to expel any member from the association who consulted with him. “Minutes, 5 July 1878. Record, L.A. County Medical Association, 1871-1891,” Los Angeles County Medical Association Collection, Huntington Library, San Marino, CA.

192 Widney was president of LACMA in 1877. Kress, A History of the Medical Profession of Southern California, 2:33; “Minutes, 31 January 1871. Record, LACMA, 1871-1891; “Minutes, 8 April 1874; 4 May 1874; 5 May 1874,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.
assumed that they were tender-hearted women incapable of managing costs.

Widney’s reforms apparently restored enough confidence in the office of the county physician that the board returned to its practice of accepting contract bids for the position in 1875. Again, a new physician named Samuel W. Brooke bid irresponsibly low to get the job, and after taking advantage of the free publicity that accompanied the position, he was not willing or able to take time away from his private patients to complete his hospital duties. In February 1876, the press exposed Brooke’s irresponsibility, and he resigned. In response to the political backlash from the scandal, the supervisors eliminated the contract system and changed the county physician to an appointed position, electing LACMA vice president Henry S. Orme to the post for a salary of $1,000 per year.193

Throughout the 1870s, LACMA sought to bolster the power of physicians at the hospital, both by shaping county guidelines for its management and by encouraging supervisors to provide the physician with adequate pay requisite for his duties. However, as evidenced by the incidents with Doctors Wise and Brooke, LACMA’s power was not unchallenged. By accepting bids from physicians whom LACMA officers considered unscrupulous, supervisors ultimately questioned the organization’s expertise and authority—they remained suspicious of whether or not physicians deserved such high pay, as some doctors were apparently willing to work for less. But, when these actions backfired on the supervisors, they turned to LACMA officers to clean up the mess, restoring public confidence in government-funded health services.

Now, this is not to say that physicians held all the power in this situation. The Daughters of Charity, physicians, and the Board of Supervisors all had a vested interest in controlling the hospital. County supervisors held the purse strings, physicians sought to extend their authority and to receive adequate salaries, and the sisters did the work of nursing patients and maintaining the hospital. Both the sisters and physicians had to negotiate with the supervisors to manage funds designated for the hospital, but the sisters were not always on an equal footing with doctors in the 1870s. While county physicians lobbied to increase their salaries, the board pressured the Daughters to accept a 25 percent reduction in their fees in 1871, and it ordered them to submit monthly bills to the board in order to more closely monitor costs in 1874.194 With only rare exceptions, all county contracts had been paid on a quarterly basis since 1860, including those for the physician, pharmacist, printer, and the hospital. So, by ordering the hospital to change its practices, the board of supervisors singled out the sisters and subtly expressed dissatisfaction with their management. Gender, lack of professional status, and to a lesser extent, religion may have influenced the supervisors’ actions.

While anti-Catholicism did not reach a fevered pitch in nineteenth-century Los Angeles, changes in the community’s religious makeup diminished the church’s political influence and weakened interreligious ties during the 1870s. As Michael Engh demonstrates, Angelenos from many faiths cooperated on issues of mutual interest during the 1850s and 1860s. Catholics, Protestants, and Jews supported St. Vincent’s College and the Daughters of Charity’s school. Believing that religious infrastructure improved the image of the town as a whole, Protestants and Jews also supported Catholic building projects, including improvements to the parish cemetery and church in the 1860s and the construction of the Cathedral of St. Vibiana in the early 1870s. Interfaith cooperation was, in part, a frontier necessity, and Engh notes that population growth and economic development reduced the incentives, for Protestants particularly, to support sectarian ventures as “community projects.”195

Despite accepting donations from non-Catholics for the cathedral, Bishop Amat remained suspicious of the development of religious pluralism in Los Angeles, and he discouraged his flock from associating too closely with those of other faiths. Between 1862 and 1877, Amat denounced Catholics’ membership in fraternal societies, including the Masons, the Order of the Odd Fellows, the Sons of Temperance, the French Benevolent Society, and even the St. Patrick Benevolent Society.196 Amat deemed these organizations to be “secret societies” that could be potentially dangerous to the church, although they also provided opportunities for Catholics to cultivate the necessary professional and personal networks to curry political favor. In an attempt to protect his flock from the spiritual dangers of Protestant encroachment, Amat may have inadvertently curtailed opportunities for Catholics to extend their influence among the new group of farmers and businessmen who were establishing themselves as political players in the 1870s.

In the 1850s and early 1860s, the interreligious cooperation that

193 Martin, History of the LA County Hospital, 12; “County Hospital Physician,” Los Angeles Herald, 12 February 1876; Kess, A History of the Medical Profession of Southern California, 2:33; “Minutes, 6 May 1874,” Book 6 (July 1873–10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.

194 “Minutes, 6 March 1871.” “Minutes, 6 May 1874.”

195 Engh, Frontier Faiths, 82-86, 92–100.

196 Ibid., 90-93, 182-185. Engh notes that in most cases, Catholics followed the bishop’s wishes on this matter. No Spanish-Mexicans joined the local Masonic lodge, and the St. Patrick Benevolent Society effectively disbanded after the bishop’s denunciation in 1877. One notable exception is the participation of John G. Downey in Masonic Lodge Number 42. An Irish Catholic immigrant, Downey served as California’s Governor between 1860 and 1862. He also co-founded Farmers’ and Merchants bank, and had extensive land holdings in the region. Engh notes that Downey was incredibly generous in supporting the construction of the cathedral, and suggests that Amat may have decided to look the other way regarding his lodge membership. Ibid., 91.
characterized Angelenos’ support for civic improvement projects created multilayered benefactor relationships that benefited both the sisters’ orphanage and their hospital. The Daughters of Charity sponsored fundraising fairs for their orphanage regularly between 1858 and 1900, and in the early years the wives of physicians and members of the board of health also worked as organizers for these events. Mrs. Thomas J. White and Louisa Hayes Griffin headed the organizing committee for the first orphans’ fair in September 1858, and Mrs. Ralph Emerson, whose husband was one of the county supervisors assigned to the Board of Health, also volunteered her time and resources. While Griffin continued to participate in the sisters’ fundraisers into the 1870s, other women whose husbands were associated with the hospital did not. Even though physicians’ wives generally played prominent roles in charitable endeavors, Ida Tuthill Widney, Mary C. Orme, and Laura J. Hannon chose not join the organizing committee, nor did the wives of the members of the Board of Health. To be fair, however, the supervisors assigned to the county’s board of health in the early 1870s lived outside the city and their wives may not have been expected to take an active role in Los Angeles social affairs.

Nevertheless, it appears the Daughters were not able to build benefactor relationships with the families of those associated with the governance of the hospital in the 1870s, making it that much easier for physicians and supervisors to see hospital affairs as “just business,” rather than charity. Weakening political ties placed the Daughters of Charity, and perhaps, Catholic interests as a whole, in a more precarious position than they had been during the previous two decades.

Despite this political situation, the sisters found ways to push back against the encroachment on their authority and autonomy as hospital owners. When county physicians neglected their duties, the sisters and their patients submitted written petitions to the board of supervisors, presumably either demanding the doctor reform his errors or that he be removed. When Dr. Vincent Gelcich’s one-year contract was up for renewal in February 1868, the board remained sensitive to the feelings of the sisters and patients and recommended that the newly elected physician reform his errors or that he be removed. When Dr. Wise was accused of misconduct, the board of supervisors initially let his business partners (physicians) handle the situation. When the patients sent their signatures to the board, the supervisors initially decided not to investigate the complaining patients’ grievances. But when the patients sent their signatures to the board, the supervisors finally took action by convening a meeting with the patients and physicians. The board of supervisors then directed the patients to keep themselves out of the situation. In contrast, the 1874 petition against Dr. Wise only included patients’ signatures. Although the sisters’ wishes were not publicly stated or entered into the minutes, they probably agreed with their patients’ assessment of the situation. Someone had to come up with the idea, collect the signatures, and send them to the board. Captured in the middle, the sisters may not have wished to rock the boat. Or, more likely, prescriptions of humility discouraged them from seeking any public attention. However, the patients, or perhaps a benefactor, may have gathered signatures detailing the grievances against Dr. Wise on their behalf. The Board of Supervisors acted as the referee during these power struggles between physicians and the sisters.

Because it was considered unseemly for sisters to do so at the time, the Daughters of Charity rarely made public statements. The 1868 petition is quite unusual because it actually states that the sisters expressed dissatisfaction with the physician in charge. In contrast, the 1874 petition against Dr. Wise only included patients’ signatures. Although the sisters’ wishes were not publicly stated or entered into the minutes, they probably agreed with their patients’ assessment of the situation. Someone had to come up with the idea, collect the signatures, and send them to the board. Caught in the middle, the sisters may not have wished to rock the boat. Or, more likely, prescriptions of humility discouraged them from seeking any public attention. However, the patients, or perhaps a benefactor, may have gathered signatures detailing the grievances against Dr. Wise on their behalf. The Board of Supervisors acted as the referee during these power struggles between physicians and the sisters. Since the board held the purse strings, both parties had to negotiate with it, and each played its political cards to gain influence. However, in the changing political climate of Los Angeles, the Catholic Church and its representatives did not hold as much sway against the growing respect and professional power of LACMA physicians. The sisters had to tread carefully.

The sisters’ ownership of the county hospital was not necessarily in the best interest of the growth of the medical profession in Los Angeles, a goal to which members of the board make a change in the position: “We further find that there is great dissatisfaction expressed by the patients and managers of the hospital in regard to the present county physician and that we recommend to the new board that they at an early day make such change as will give satisfaction to the patients, managers, and public.” John S. Griffin was reappointed as county physician the following week. Griffin had held the office nearly continually since 1859, and so he was presumably someone with whom the sisters could work. Even so, Griffin felt the need to reassert his authority at the hospital by getting the endorsement of the board in June 1868: “It is ordered that he [Griffin] be and is hereby authorized to establish such regulations as he may think best and proper for the interest of the patients and managers of the county hospital.” Although the specific details remain unknown, it appears there may have been some tension between the physician and the sisters over control of the institution.

198 According to the census data, Henry S. Orme, county physician in 1871-1872 and 1876, was married to Mary C. Orme, and Joseph D. Hannon, county physician in 1877, was married to Laura J. Hannon. Members of the Board of Health in 1873 included Francisco Palomares, George Hinds, and Edward Evey. Francisco and Lugarda Palomares lived in San Jose, near La Puente, twenty-two miles east of Los Angeles; George and Mary Hinds lived in Wilmington, approximately twenty-one miles south of Los Angeles; and Edward Evey (a widower) lived in Anaheim, twenty-six miles southeast of Los Angeles. U.S. Census, Los Angeles, 1870; U.S. Census, Los Angeles, 1880. Joseph P. Widney, county physician in 1874, married Ida D. Tuthill in May 1869. She died on 10 February 1879, and Widney married Mary Bray on 29 December 1882. Rand, *Joseph Pomeroy Widney*, 80.


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199 “Minutes, 28 February 1868,” Book 4 (November 1867-May 1871), Historical Board Minutes, Box 2, LACBS, Los Angeles.

200 “Minutes, 4 March 1868,” Ibid.

201 “Minutes, 1 June 1868,” Ibid.

202 “Minutes, 6 April 1874,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.
LACMA was firmly committed. The sister-nurses were not trained in the newest techniques, they had little capital to invest in operating rooms or experimental research, and they insisted on maintaining control over hospital conditions. Since physicians had few options in the early 1870s, more often than not, they probably acquiesced to the sisters’ wishes. But, tensions over hospital control may have led many to support the establishment of an independent hospital where physicians could have more influence. In fact, Dr. John S. Griffin, long-time county physician and an attending physician at the Los Angeles Infirmary, sold land to the county to build a hospital in 1878. As a founder and past president of LACMA, professional considerations took precedence over any loyalty to the sisters.

LACMA’s efforts to control hospital affairs collided with the established presence of the Daughters of Charity and their dominance over health care targeting the poor. The sisters acted as primary caretakers for the sick poor in Los Angeles, and although not antagonistic towards change or diametrically opposed to physicians’ interests, the Daughters remained committed to their responsibilities as advocates of for people living in poverty. Patients came before professional interests, and the Daughters put charity first. To do this, the sisters needed the autonomy to direct and control the Los Angeles Infirmary. In the 1860s, the sisters’ autonomy went relatively unchallenged, but urban growth, weakening political ties, and the professionalization of medicine changed the political climate surrounding charity services in the 1870s, complicating the sisters’ advocacy for poor persons in the city.

NEW COMPETITION: THE GROWTH OF MEDICAL INSTITUTIONS IN LOS ANGELES

As part of the efforts to enhance the healthy image of Los Angeles, physicians established new medical institutions and developed new strategies for assisting the sick poor in the 1870s. The French Benevolent Society opened a hospital in 1869, and LACMA members opened the Los Angeles Free Dispensary in 1877. These efforts represent the intervention of private charities into the medical marketplace. Before this time, the Daughters of Charity managed the only hospital in town, and backed by county funds, they were often vulnerable to the political vicissitudes of a publicly financed institution. The sisters’ funding problems, the city’s population growth, and national trends towards ethnically-oriented private hospitals encouraged others to enter the medical marketplace in Los Angeles.

In an age without social security, immigrant mutual assistance associations provided a measure of financial security for immigrant laborers. The societies often provided accident, sick and death benefits, as well as opportunities to build friendships, make business contacts, and preserve cultural heritage. These benevolent societies also provided food and financial assistance to needy families, especially newcomers to the city. Mutual assistance societies popped up in Los Angeles in the mid-nineteenth century, as they did elsewhere in the country. Jews founded the Hebrew Benevolent Society in 1854, the first mutual assistance association in Los Angeles after American rule. The French Benevolent Society came next in 1860, and by 1880 the city had Irish, Scot, German, Italian, and Spanish American societies.

By the 1870s, benevolence associations turned their attention to providing medical care and hospital services for their members. Ethnically or religiously oriented hospitals provided interpreters, special diets, and spiritual care for their patients, which they might not find at the city almshouse. Germans, Italians, Poles, and Jews opened hospitals in New York, Philadelphia, Chicago, Baltimore, and other major cities. Religious competition also fed the movement to build hospitals. Episcopalians, Lutherans, and Methodists started building hospitals in the late nineteenth century in response to Social Gospel concerns about the excesses of urbanization, but some Protestant reformers encouraged the establishment of hospitals as a direct effort to counter Catholic efforts. Anti-Catholicism does not appear to be a motive in the founding of ethnically-oriented hospitals in Los Angeles, but shared language and culture may have been a large factor.

By the mid-1870s, mutual assistance societies sprung up in the French, German, Irish, and Hispanic communities in Los Angeles. In part because of Bishop Amat’s opposition to “secret societies,” the Irish St. Patrick’s Benevolent Society ceased to function by the end of the decade. However, the German, Italian, and Spanish-American societies decided to address the health care needs of their members, albeit with different strategies.

206 Engh, Frontier Faiths, 184-185.
207 To distinguish themselves from newly arrived Mexican immigrants, elite Californios started to call themselves Spanish-American in the late nineteenth century. Along with Hispanics in other western states, Spanish-Americans used this term to emphasize their American citizenship and to maintain their claim as members of the white race, a status generally conferred because of the wealth and social status of Californios families before the Mexican War. Their children and grandchildren wished to retain the privileges of whiteness and continued to emphasize their European heritage. However, like other immigrant groups, the Spanish-American community saw the value of establishing mutual aid societies. According to Emilio Zamora, these mutualistas offered financial assistance to their members, including life insurance. Many provided opportunities for members to become involved in civic affairs, and they often sponsored schools and newspapers. Zamora notes, “Mutualista organizations thus gave their members and communities a sense of belonging and refuge from an often alien and inhospitable environment.” As more Anglo-Americans migrated to Los Angeles from the east, Californios felt more out of place, despite the fact that many had lived in the region for generations. Eileen V. Wallis, “Keep-

203 Martin, History of the LA County Hospital, 17-18.
Benevolent Society opened its hospital in 1869, and the German Benevolent Society announced its intentions to build a hospital in 1877. They also hired Dr. Joseph Kurtz who, incidentally, was LACMA vice president that year, to provide medical services for the society’s members. Besides providing assistance for poverty-stricken German newcomers, the society promised members the “right to have medical aid and medicine, free of charge.”

Open to both men and women, the German Benevolent Society counted one hundred members in 1877, although the numbers probably fluctuated throughout the decade.209

While the French and German Benevolent Societies chose to open their own institutions, the Italian and Spanish-American societies decided to maintain their relationship with the sisters’ hospital. The Italian Benevolent Society endowed a room in the sisters’ hospital that provided care for its members at six dollars per week. The fee covered room, board, and nursing care, but the society would pay the additional charges for physician attendance and medicine.210 The Italian society chose to send its members to an existing hospital amenable to its Catholic traditions, and the Spanish-American community followed suit. In October 1877, the Common Council approved an ordinance granting land to the Spanish-American Benevolent Society for “hospital purposes,” as long as the hospital opened in less than six months.211 This move suggests that city officials tried to channel business away from the county-funded hospital, shifting the burden for patient care to private charity. The timing was significant, since the county was in the midst of a legislative battle to secure state approval for a new county hospital. As president of the Sociedad Hispano Americana de Beneficencia Mutua, Antonio F. Coronel declined the land for the proposed hospital, citing the society’s financial difficulties.212 Ygnacio del Valle also demonstrated his support for the sisters by staying at the hospital during his illnesses.213 By declining the land and lending their personal reputations to the hospital, the Spanish-Mexican community demonstrated their support for the Daughters of Charity.

The French Benevolent Society established the most successful ethnic medical institution, but it could not survive financially by only serving the French community. Membership to the society was open to all Angelenos, regardless of language ability or ethnic heritage. Members contributed one dollar per month to the society, supplemented by the annual fundraiser, a picnic hosted by the society in the Arroyo Seco. Besides supporting the hospital, the fundraiser had the additional benefit of solidifying support for the association, potentially attracting new members, and providing an opportunity for social interaction among the community. To maintain its financial stability, hospital administrators also opened up the facility to non-members. Advertising in the Spanish and English press, the society noted that non-members could receive treatment for $2.50 per day, without any additional fees for physician’s services. It also offered discounts to members of other mutual assistance societies.214 Despite the French Benevolent Society’s openness to the community, the need for fundraisers suggests the financial difficulties ethnically-oriented institutions faced during the 1870s.

The development of these new medical institutions suggests that the sisters’ hospital could not completely meet the demands for hospital care in a growing city. For doctors, an increased number of hospitals represented opportunities for increased notoriety and wealth. Dr. S.H. Nadeau may have provided “gratuitous professional services” to patients at the French Hospital, but he may have done so in order to strengthen his private practice.215 Becoming the French Benevolent Society’s physician assured him status among its membership and provided an automatic client base. Dr. Joseph Kurtz accepted a similar role in exchange for the hospital’s continued use of his name and address.216


209 “German Benevolent Society,” “German Benevolent Society Advertisement,” Evening Republican, 6 February 1877. See also Baur, “Private Philanthropy in Nineteenth-Century California,” 127-128. In 1877, the society also owned two acres of land in East Los Angeles, had assisted eight families, and paid out ninety-four dollars in medical assistance. They also sponsored a masquerade ball on 10 February 1877. It is unclear when the German Benevolent Society’s hospital actually opened, but it moved to a new location on Soto Street in 1904. See, The Los Angeles Examiner, 30 October 1904, page 3.


211 “City Council Minutes,” Evening Republican, 6 April 1877.


213 Ygnacio del Valle wrote a letter to his son from Sisters’ Hospital in February 1880, but he may have stayed at the hospital more than once during this time period. Ygnacio del Valle to Reginaldo F. del Valle, 9 February 1880, Reginaldo F. del Valle Collection, Box 1, HM 43944, Huntington Library, San Marino, CA.


215 “French Benevolent Society Advertisement.” Note: Although the newspaper advertised Nadeau’s “gratuitous professional services,” this probably meant that patients did not pay physicians fees in addition to those of the hospital. Dujardin-Demeestere notes that the society’s physician received a monthly stipend in exchange for daily attendance of patients at the hospital. Dujardin-Demeestere, “La Société Française De Bienfaisance Mutuelle De Los Angeles.”

General Collection (1001), Document No. 283, Seaver Center, Los Angeles.
position from the German Benevolent Society. Membership in the society included the “right to have medical aid and medicine, free of charge,” but it also guaranteed Dr. Kurtz either a monthly salary or a large portion of the dues.216

Protestant physicians also organized charitable medical institutions in mid-1870s Los Angeles. Following a trend in eastern cities, Dr. Walter Lindley established the Los Angeles Free Dispensary in June 1877. Dispensaries sought to reduce long-term health care costs for the county by providing out-patient care for the city's poor.217 The Free Dispensary Society rented a building and provided the free services of a physician and apothecary for two hours each day. Patients would be charged to help cover the costs of the “drugs in bulk and for the rent of the building,” but physician and apothecary services would be free.218 The dispensary's proponents contended that the poor tended to avoid seeking medical treatment because they could not pay for the doctor's visit or medicine. Even if a physician treated them for free, the prescription costs often proved prohibitive. Interestingly, the Board of Supervisors appropriated $500 for the Daughters of Charity to start a dispensary on 5 April 1877, although there are no records which confirm whether the facility actually opened. If it was active, then the sisters would have relied on the County Physician, Dr. Joseph Hannon, to examine patients and dispense prescriptions. Lindley opened his facility in June, and five months later the supervisors appropriated his dispensary twenty dollars per month “during the pleasure of the board.”219 Hannon did not participate in Lindley's clinic, so it is unlikely that Lindley collaborated with the Daughters in a single dispensary. Indeed, Lindley and his partners may have competed with the sisters in the dispensary market, and if this was the case, the Board of Supervisors revealed their preference for professional, physician-led medical services by appropriating funds for the Los Angeles Free Dispensary.

New medical institutions, particularly charitable ones, played into boosters' portrayal of Los Angeles as a “modern” city. To attract new business, investment, and immigrants, the city needed to provide facilities comparable to other great cities. Promoters of the free dispensary directed their fundraising appeal toward this booster mindset. The board pointed to the city's sense of pride and desire to be seen as modern and respectable: “In almost every city of ten thousand inhabitants and upwards this emergency is provided for by Free Dispensaries, where the sick poor, who are able to walk are treated by competent physicians and supplied with medicines without cost. Such a charity as this is much needed in Los Angeles....”220 The Free Dispensary represented an effort by private charities to take more responsibility for health care of the indigent sick, but the dispensary, like the hospitals, also served to enhance the reputations of its physicians. A relatively new physician in town, Lindley parlayed his experience treating the poor at the dispensary into an appointment as City Health Officer in 1879 and Superintendent of the County Hospital in 1885.221 The Free Dispensary provided an opportunity for physicians to serve the community, but for Lindley, the clinic also represented a strategy to establish his reputation, and to jump-start his medical career in Los Angeles. In sharp contrast to the sisters' approach, charitable care served as a vehicle for physicians’ professional development.

216 “German Benevolent Society,” *Evening Republican*, 5 February 1877.
219 Ibid.; "Minutes, 5 April 1877,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles; “Minutes, 8 November 1877,” Ibid.
Chapter 4
Advocacy for the Sick Poor and a New County Hospital, 1870-1878

The economic boom which brought growth and prosperity to Los Angeles collapsed in the late 1870s. The national economic panic that began in 1873 reached the city by the summer of 1875. Rampant speculation in the Nevada mining districts resulted in a run on the supposedly “impregnable” Bank of California in San Francisco on 25 August 1875. As the panic spread to Los Angeles the following day, depositors hastily withdrew their funds from such major banking institutions as Farmers and Merchants Bank and the Temple and Workman Bank. Isaias W. Hellman's conservative banking practices saved Farmers and Merchants, but F.P.F. Temple's liberal loans forced his bank to close its doors forever. In his memoir *Gold and Sunshine* (1922), Colonel James J. Ayers recounts the bank failure's effect on the Los Angeles economy: “The depositors of the Temple & Workman bank were severely crippled, and some entirely ruined, and the loss of confidence entailed upon the community was such that business in all its departments was carried on in so conservative a way that expansion and progress were out of the question for several years.”

To make matters worse, the Inyo silver trade dwindled in 1877, drought struck the region, crops failed, and smallpox assaulted the city. The boom ended, and times looked desperate indeed.

The depression created a situation which severely strained the relationship between the sisters and county officials. The partnership between the Daughters of Charity and the Los Angeles County Board of Supervisors worked well when Los Angeles was a small frontier town, but urban growth in the midst of the national economic crisis pushed both the political and economic limits of its feasibility.

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The panic increased unemployment, leaving many men sick, malnourished, and unable to pay for their care. Demand for county support increased just at the time tax revenue decreased, leaving the sisters vulnerable to accusations that they treated indigent patients too well and overcharged the county for their services. Therefore, some argued that the county should relieve the sisters from the management of its charity patients. Faced with mounting political pressures, the County Board of Supervisors and the Daughters chose to end their collaborative arrangement in 1878. Instead of bowing to outside pressures, the sisters chose to maintain their autonomy and stay true to their mission, come what may.

THE SISTERS AND SMALLPOX EPIDEMICS

Besides providing ongoing care for the county’s sick at the Los Angeles Infirmary, the Daughters of Charity also collaborated with city officials in meeting emergency public health needs during periodic smallpox epidemics in the late nineteenth century. Following California’s patterns for the distribution of public health responsibilities, the Common Council—not the County Board of Supervisors—took the lead in combating epidemics. The council then turned to churches and private charity organizations for additional support. The Daughters volunteered to staff the pest house, or quarantine hospital, during the smallpox epidemics of 1862-1863, 1868-1869, 1876-1877, 1884, and 1887. The Hebrew Benevolent Society also raised funds to provide food for afflicted families. By 1877, for example, a smallpox epidemic posed a significant challenge to the city’s reputation as a “healthful place.” Striving to protect their bottom line, businessmen pressured city officials to take a more comprehensive approach to public health. But for their part, the Daughters of Charity remained fixed on improving the quality of health services for the sick poor, many of whom suffered from government inefficiency and neglect.

During smallpox outbreaks, Los Angeles officials developed a three-pronged approach to halt the spread of the disease. First, the city appointed health inspectors to find and report smallpox cases. The inspectors posted yellow quarantine flags in front of patients’ homes, warning the neighborhood of the presence of the disease and restricting the movements of household members. Second, the city opened a quarantine hospital, or “pest house,” to treat indigent patients who could not afford to pay physicians’ fees. Patients without family members to provide nursing care were also sent to the pest house. Third, the city embarked on vaccination campaigns, offering smallpox vaccinations free-of-charge to city residents. These strategies worked with varying degrees of effectiveness.

As in other cities, Angelenos expected government intervention to be temporary. When smallpox first appeared during the winter of 1862, the city appointed a board of health and Mayor Damien Marchessault hired inspectors to canvass Los Angeles and report every case that appeared. Marchessault also purchased a “pest house” four miles outside of town and asked the Daughters of Charity to nurse patients there. One sister remembered that when Sister Scholastica and Sister Ann went to inspect the pest house, they found “patients lying pell-mell on the floor, suffering in every way... Some becoming delirious from fever, would rush out over the patients thickly strewn over the floor.” After seeing patients in such a “pitiable condition,” the Daughters agreed to take charge of the pest house, cleaned it up, and began caring for those afflicted with the disease. Although it is likely that relatively few deaths occurred at the pest house, approximately one hundred people died during the epidemic, many of them Mexicans and Native Americans. However, as reports of the disease dwindled, the board of health requested permission to disband in March 1863. The Common Council agreed, and probably closed the pest house as well. Angelenos did not expect the board of health to become a permanent fixture in city government.

Historian Jennifer Koslow notes that the Common Council followed similar patterns during an epidemic in the winter of 1868 and spring of 1869. Like in other cities, Los Angeles officials used both the contagionist and sanitary approach to halting the spread of disease. The council appointed a temporary board of health, quarantined patients at home, and hired Dr. Henry S. Orme to administer smallpox vaccinations. Quarantining patients and administering vaccinations appeased the “contagionists,” who believed that microscopic organisms caused the disease. But the council also engaged in sanitarians’ city cleansing efforts by instructing Orme to report public health “nuisances,” such as poor sewerage, rotting animal

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227 Ibid., 81.

228 “Remarks on Sister Mary Scholastica Logsdon,” 113. Because of the nature of the source, there may be some inaccuracies in the account. This comment most likely refers to the 1862-1863 smallpox epidemic, but it is not dated. In general, few sources remain which discuss the epidemic in detail. The 1903 account asserts that the sisters requested the city move the pest house closer to town, so they could have better access to patients, and also claims that a family moved out of the home to accommodate the pest house. It is unclear whether this request was made in 1862 or 1869, and I have not been able to corroborate this with evidence from other sources.

... carcasses, and filthy pig sties. The council also mandated that all children had to be vaccinated before attending school, and the city built a new pest house in the fall of 1868.230 Although the number of cases dwindled by December 1868, the disease reemerged in May 1869. The Common Council then asked the Daughters of Charity to nurse patients at the pest house, which they did until the epidemic subsided at the end of June. At that point the council dismissed Orme, disbanded the board of health, and closed the pest house.231 As in 1863, city officials responded to this health crisis through the temporary expansion of government authority. While scientific theories of disease and political support for limited government shaped American public health practices during the nineteenth century, smallpox and other contagious diseases also exacerbated racial and class tensions in communities throughout the United States. In 1863 and 1869, smallpox disproportionately affected the Mexican and Native American population in Los Angeles, and by 1876, the press blamed the “festering filth” in Chinatown for the reemergence of the disease.232 By labeling Chinatown the city’s “plague spot,” historian Natalia Molina argues that the press, and city officials, “assigned responsibility for these conditions to the area’s Chinese residents,” rather than to the Anglo landlords who ignored sanitary conditions.233 As they deflected attention from economic exploitation and racial prejudice, Los Angeles officials started to conflate race with poverty and public health threats. If, as some Angelenos believed, Chinese culture encouraged poor hygiene, opium addiction, and immoral behavior, then Chinese immigrants needed to be contained as a means to protect public health. As Molina demonstrates, quarantine measures and public health ordinances disproportionately affected people of color, thus reinforcing images that constructed Chinese and Mexican residents as “foreign” and “dangerous” to the American citizenry. Likewise, class biases also shaped public responses to smallpox epidemics. In his study of nineteenth-century cholera epidemics, Charles Rosenberg explained that many middle-class Americans underreported cholera cases in their families to avoid association with the “shameful disease,” assumedly brought on by the dirty, intemperate, and immoral behavior of the “dishonorable” poor.234 Sensitive to this image, Los Angeles officials developed a class-based response to the needs of smallpox patients. Middle-class patients could remain in their homes, treated by family members and a private physician. Nor were quarantines always strictly enforced. However, poor patients were unceremoniously scurried out of town by the health officer and forced to endure the humiliation of being treated in the pest house. Like nineteenth-century almshouses, pest houses often suffered from government inefficiency and neglect. Upon her arrival at the Los Angeles pest house in 1887, Sister Veronica Klimkiewicz noted the building was in such a state of disrepair that it was “hardly fit for domestic animals.” The city had hired incompetent and unreliable caretakers, for whom “the large pecuniary consideration offered was the principal, if not the only inducement to enter so repulsive a service.” Because of the filthy conditions and a reputation for indifferent care, Sister Veronica explained, “As a consequence, none, or very few, who were in circumstances to resist the public pressure that sought to force them into such dire isolation, could be induced to leave their homes.”235 Justifiably, most Angelenos avoided entering the quarantine hospital for fear of living in squalor, and thus hastening death.

Building on antebellum trends that contained the deviant, depraved, or simply the poor into public institutions, Californians started to regulate, isolate, and contain racial others as “threats to the health of the community” in the late nineteenth century. Although often underfunded and understaffed, historian Nayan Shah illustrates that public health officials held considerable “legal authority to regulate property and people’s conduct.”236 As seen through the smallpox epidemics, class and racial biases often mediated the application of this authority, and continuing disdain for the poor—especially those afflicted with contagious diseases—led to inadequate funding for facilities, nursing care, and sanitation. Despite these prejudices, the Daughters of Charity engaged with city officials to improve conditions for the sick poor by nursing individuals without regard to

230 The Daughters of Charity requested the pest house be moved closer to town, although it is not entirely clear whether this was done in 1869 or 1877. According to the 1884 Stevenson map, the pest house was located on Reservoir Street, near Adobe, adjacent to the Hebrew Cemetery. This is approximately the same location that the Common Council deeded to the sisters for “hospital purposes” in 1857. “Deed, The Mayor & Common Council of the City of Los Angeles to the Novice Sisters of Charity, 2 May 1857”; “Remarks on Sister Mary Elena Logsdon,” 113; Stevenson, “Map of the City of Los Angeles.”


235 Veronica Klimkiewicz, D.C., to Euphemia Blekinsop, D.C., 20 June 1887, Maryvale Historical Collection, Maryvale, Rosemead, CA. Copy consulted at SVMCHC, March 2009. Sister Veronica Klimkiewicz (1837–1930) joined the community in 1854 and served in twelve of the sisters’ institutions (schools, orphan asylums, and hospitals) in the eastern United States before coming to the Los Angeles Infirmary in 1884. She also nursed wounded soldiers after the battle of Gettysburg in 1863. McNeil, “Daughters of Charity as Civil War Nurses,” 164–165; “Veronica Klimkiewicz, D.C.,” Entry in Daughters of Charity, Consolidated Database (10–0), APSL.

236 Shah, Contagious Divides, 6.
race or creed. The sisters thereby challenged those deeply ingrained notions of inequality which dominated society in the nineteenth-century American West.

**THE DAUGHTERS OF CHARITY AND ADVOCACY FOR THE SICK POOR**

Although nineteenth-century gender ideology and convent education discouraged sisters from speaking publicly or making overt political moves, the Daughters of Charity quietly defended the interests of the sick poor by carefully negotiating the terms under which sisters would labor. During public health emergencies such as the smallpox outbreaks, the Common Council needed the Daughters of Charity to lend their angelic reputation to the pest house in order to convince more patients to enter isolation and hopefully slow the advance of the disease. As Sister Veronica Klimkiewicz later explained, city officials hoped “few would refuse to go where such ministrations as theirs were offered.”237 But the sisters agreed to step in only if the city provided improved facilities and adequate funding for patient care. Knowing this, the Common Council often delayed hiring the Daughters as long as possible, presumably to avoid spending money unnecessarily on the “unworthy poor.” They accepted the sisters’ service when the disease reached truly epidemic proportions. By insisting on ample funding and decent conditions, the Daughters of Charity ensured that both the sisters and their patients would be treated with compassion and respect. If public officials could not (or would not) meet the sisters’ terms, the Daughters would withdraw their services and force officials to look elsewhere for skilled nurses and administrators. By skillfully applying their political leverage, the sisters acted as agents of change, countering disparaging views of the poor and aiding social castaways who had nowhere else to go.

Pest house conditions were deplorable under the city’s management. In 1877, patients included Irish immigrants, Mexicans, Native Americans, and others without families to care for them.238 Even though the pest house was isolated on the outskirts of town, few Angelenos wanted to risk contracting smallpox by delivering supplies, washing laundry, or nursing patients. The temporary nature of the emergency also provided little incentive for council members to invest in improving pest house conditions. Before the sisters arrived the facility reeked with filth, fleas and lice covered the bed linens, and some patients “were at times a literal mass of corruption with maggots crawling from their ears and nose.”239 Unsurprisingly, few smallpox patients chose to be treated in the pest house. Only one-quarter of the 360 cases reported in 1876 and 1877 received treatment at the facility.240 Few sick Angelenos risked entering, perhaps because of fear of social disparagement, but more likely because they feared their condition would worsen due to the city’s lack of care.

Political pressure from the Grand Jury, and an angry citizen’s committee, forced the Common Council to take more comprehensive action to safeguard the health of its citizens. After an explosive council meeting, Sister Scholastica sent a message to city hall. On 8 February 1877, she offered “to take charge of a suitable pest house, at the rate of $3 per day for each patient, the Council to furnish physicians and medicines.”241 The sisters agreed to supply all the provisions for the establishment, including wine and liquor, but the city would continue to provide other medicines, bedding, and clothing for patients. Sister Scholastica also required the city to construct a two-story wooden building (eighteen feet square) for the sisters-nurses to live in. The city would continue to maintain a wagon and driver for the use of the hospital, arrange burials as needed, and patients would not be allowed to bring liquor into the hospital without permission.242 The sisters’ offer was unanimously accepted on 8 February, the council paid nearly two thousand dollars ($1986) for a new building on 24 February, and the Daughters of Charity probably took charge of the pest house on 25 February 1877.243 The sisters’ presence had an immediate effect. On 2 March, the health officer reported that twenty of the fifty-nine cases of smallpox reported in the city were being treated at the pest house, nearly doubling the percentage of afflicted patients receiving care at the facility.244 As was evident, the Daughters’ reputation boosted Angelenos’ confidence in the city’s public health efforts.

By requesting a “suitable pest house,” the Daughters of Charity used their

237 Klimkiewicz, to Blekinsop, 20 June 1887.

238 While under the sisters’ management between 25 February and 14 April 1877, thirty of the thirty-eight patients were men. The rosters listed three Indians, and most of the other patients had Spanish or Irish surnames. “Pest House Warrants, 20 April 1877,” Minutes of City Council, Volume 10, 12, City Treasurer, Bills Paid, Los Angeles City Archives, Los Angeles.

239 Klimkiewicz, to Blekinsop, 20 June 1887.

240 “Health Officer Reports,” Evening Republican, 20 October 1876-20 April 1877; “City Council Minutes,” Evening Republican, 9 February 1877; “Concilio Comun,” La Cronica, 13 January 1877; “Pest House Warrants, 20 April 1877.”

241 “City Council Minutes,” Ibid.

242 “Concilio Comun,” La Cronica, 10 February 1877.

243 “City Council Minutes,” Evening Republican, 24 February 1877. The first bills recording payments of three dollars per day per patient began on 25 February, so the sisters must have taken over the pest house around that time. See “Pest House Warrants, 20 April 1877.”

244 On 9 February, the health officer reported fifty-three cases in the city; ten were being treated in the pest house. “City Council Minutes,” Evening Republican, 9 February 1877. On 2 March, the health officer reported fifty-nine cases in the city; twenty were being treated at the pest house. “City Council Minutes,” Evening Republican, 2 March 1877.
political influence to improve the quality of life for their patients, forcing the council to pay for improvements and increasing patients’ confidence that they would receive quality care. The sisters also required sizeable funds to cover the cost of a patient’s treatment. The sisters asked for three dollars in gold per patient per day from the Common Council, whereas the County Board of Supervisors only paid seventy-five cents per day for patients at the Los Angeles Infirmary.

The sisters probably required payment in gold because of the recent economic crisis in Los Angeles. Paul R. Spitzzeri notes that city treasurer J.J. Mellus deposited $23,000 of the city’s funds in the Temple and Workman bank early in 1875. Unfortunately, the bank fell victim to the August financial crisis sparked by overspeculation in Nevada’s Comstock silver trade. In response to the panic caused by the closure of San Francisco’s Bank of California on 26 August 1875, both the Los Angeles banks (Farmers’ and Merchants’ Bank and the Temple and Workman) temporarily closed their doors. Farmers’ and Merchants’ reopened on 1 October, but F.P.F. Temple was unable to secure a loan for some time and could not reopen his bank until 6 December 1875. Unfortunately, Elias J. (“Lucky”) Baldwin’s loan was not enough to save the bank. The Temple and Workman Bank closed permanently on 13 January 1876. According to Spitzzeri, the city likely lost all of its funds. See Paul. R. Spitzzeri, The Workman and Temple Families of Southern California, 1830-1930 (Dallas: Seligson Press, 2008), 159-193. In particular, pages 164 and 184 discuss the city’s connection to the bank failure. While the sisters did not contract with the city to care for smallpox patients until February 1877, the requirement to be paid in gold suggests that there was still some hesitancy on the sisters’ part about the council’s ability to pay its bills.

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246 Klimkiewicz, to Blekinsop, 20 June 1887.

247 Ibid.
needs and to a nearer communion with God.” These circumstances, in addition to the various experiences that she feared “would prove a harrowing scourge for the remainder of life.” The Daughters offered spiritual comfort and practical help. They listened to patients, taught spiritual values, and invited priests to offer the sacraments. But, the sisters also went to work cleaning the building, replacing the sheets and blankets, and “so changing and transforming the whole house that the Resident Physician said of it, ‘what was once a hell has become a paradise since the Sisters took matters in charge.’”

The Daughters of Charity maintained a tradition of courageous self-sacrifice during epidemics. When others fled, Catholic sisters remained in cities like Baltimore and New Orleans during the cholera epidemics of 1832 and 1848. Their willingness to risk infection and death did much to soften anti-Catholic attitudes in the United States and opened doors for further expansion of their missions. Along with the sisters’ service in the Civil War, the cholera epidemics further solidified Catholic sisters’ reputation to provide quality nursing and garnered support for Catholic hospitals. In Los Angeles, the Daughters also stepped up to provide service during the smallpox epidemics. Their reputation for kind, caring, and effective nursing encouraged sick Angelenos to enter the quarantine hospital, isolating patients and hopefully retarding the spread of disease. Knowing that city officials needed them, the sisters leveraged their labor and growing reputation as a means to insist the city improve conditions in the pest house and provide adequate funding for the sick poor.

Increasing Public Criticism, 1875–1878

Increased migration and a smallpox epidemic contributed to skyrocketing public health costs in 1869, and in an effort to stave off fiscal disaster, the Los Angeles County Supervisors sought additional funding from the state legislature in 1870. When their petitions were refused, officials looked at other ways to reduce costs. Although it had not publicly advertised for bids “for the maintenance of indigent sick at the hospital.” During the sisters’ partnership with the county, the Board of Supervisors only required the sisters to submit formal bids twice. The first time was on 10 January 1861, when the supervisors instituted the contract system. The second was on 18 February 1871, as discussed above. The board required physicians and pharmacists to submit bids every two to three years, if not annually. Throughout the 1860s and 1870s, various physicians and pharmacists competed for the county contracts, and thus the positions rotated to different professionals throughout the community. However, no one ever openly competed with the Daughters of Charity to take care of charity patients. Therefore, the board’s decision to require bids in 1871 was not about fair competition in the bidding process. It clearly sent the sisters a message about costs. “Minutes, 10 January 1861”; “Minutes, 18 February 1871,” Book 4 (November 1867–May 1871), Historical Board Minutes, Box 2, LACBS, Los Angeles.

251 During the sisters’ partnership with the county, the Board of Supervisors only required the sisters to submit formal bids twice. The first time was on 10 January 1861, when the supervisors instituted the contract system. The second was on 18 February 1871, as discussed above. The board required physicians and pharmacists to submit bids every two to three years, if not annually. Throughout the 1860s and 1870s, various physicians and pharmacists competed for the county contracts, and thus the positions rotated to different professionals throughout the community. However, no one ever openly competed with the Daughters of Charity to take care of charity patients. Therefore, the board’s decision to require bids in 1871 was not about fair competition in the bidding process. It clearly sent the sisters a message about costs. “Minutes, 10 January 1861”; “Minutes, 18 February 1871,” Book 4 (November 1867–May 1871), Historical Board Minutes, Box 2, LACBS, Los Angeles.

252 “Minutes, 6 March 1871.” The minutes never list the sisters’ previous rate, but the Los Angeles Star picked up the story and noted that the contract resulted in a reduction from one dollar to seventy-five cents per patient per day. “Hospital Item,” Los Angeles Star, 7 March 1871.

253 In 1869 and 1870, Dr. John S. Griffin earned $187.50 per quarter, or $750 per year, for medical attendance on patients at the county hospital and jail. In 1871, Doctors Henry S. Orme and R.T. Hayes bid $499 per year, or $124.50 per quarter, for the same services. In 1869 and 1870, Theodore Hollweber received $400 per year for providing medicines to the county hospital and jail. In 1871, J.B. Saunders undercut that bid by $50, charging the county $350 per year. “Minutes, 6 March 1871.”

254 “Evening Republican, 9 February 1875,” in The History of the Los Angeles County Hospital (1878–1968) and the Los Angeles County–University of Southern California Medical Center (1968–1978) (Los Angeles: University of Southern California Press, 1979), 11. Note: No copies of the original source have survived. The only microfilmed copy of the Republican is at the Los Angeles County Public Library in Rosemead, and it starts in September 1876.
for the county’s stinginess and inadequate support for the hospital. In an unusual move, sixty-six patients signed a letter to the paper to counteract the charges:

In answer therefore, we the present inmates of the Los Angeles County Hospital would respectfully state that we are entirely satisfied with our maintenance, in all that pertains to food, fires and the mode in which the institution is conducted. As beneficiaries of the public bounty, we feel grateful to every taxpayer that there is such a noble provision for suffering humanity as our County Hospital; and the gratitude we owe those most intimately concerned in the management of its affairs impels us to refute such unfounded statements as your own, which if believed by the public, would work a prejudice against the most humane public enterprise the taxpayers are called upon to support.255

Whoever wrote this letter recognized the precarious political situation the sisters faced in maintaining their hospital, and they took a public stand supporting the sisters’ management.

Charges of negligence, poor food, and total disregard for a patient’s comfort struck at the heart of the sisters’ reputation. They could not claim to have the most modern facilities, but the Daughters built relationships of trust with the community and attracted private patients through their reputation for quality, nurturing care. Criticism not only affected political attitudes about public support, but it also threatened the sisters’ ability to attract private patients. In 1868 and 1874, the Daughters of Charity, or their advocates, registered concerns with the board privately, so as not to disrupt the sisters’ reputation.256 But when public criticism of the hospital emerged in the press in February 1875, supporters chose to fight fire with fire, making hospital conditions and the sisters’ management a matter of public debate.

Unfortunately, the effects of the economic crisis continued to focus attention on hospital costs throughout the rest of 1875 and 1876. The most damaging reports came with the fall Grand Jury inspections. The Grand Jury system established a method of county government accountability. Each year, the men appointed to the Grand Jury investigated criminal cases and proposed indictments. They also inspected the county jail and county hospital. This system provided accountability for the use of public funds and also offered a forum for citizens to recommend future courses of action. For example, the Grand Jury recommended that the Board of Supervisors apply for state aid for the hospital in 1870. The foreman, George R. Butler, claimed that the large numbers of non-resident patients “impos[ed] a heavy and unjust tax upon our citizens.”257 Butler’s recommendation showed the supervisors that county residents were frustrated with the problem of the non-resident indigent sick and they were open to seeking state support for their charitable needs. It gave the supervisors a political leg to stand on, and the option to make drastic cuts when their petitions were unsuccessful. Tracing the Grand Jury reports provides a window on hospital conditions, but it also illustrates times when the supervisors’ actions were supported by the attitudes of community representatives.

Although juries praised the sisters’ management of the hospital early in the decade, the Grand Jury became a venue to criticize the sisters in 1875 and 1876. In September 1875, the Grand Jury reported that the hospital had inadequate heat, and patients suffered unnecessarily because medicine delivery was routinely delayed. The Grand Jury recommended the purchase of new stoves, but its members also took a political stand by suggesting the sisters be removed from the management of the hospital. In their opinion, city and county officials should consider “the expense of keeping the hospital on the present plan, and we most earnestly recommend that they either separately or jointly take some steps to provide a County Hospital which shall belong to the county or county and city.”258 Although the Grand Jury pointed to deficiencies in hospital conditions, cost remained the overriding concern in the midst of the banking crisis in Los Angeles. Importantly, these men assumed government could perform the same functions more cheaply than tender-hearted women running a private charitable institution.

To further complicate matters, complaints arose against the county physician, Dr. Samuel W. Brooke in February 1876. Brooke served as county physician from January 1875 to April 1876. To establish his reputation as a new physician in the city, Brooke underbid for the county physician contract, charging forty dollars per month for medical attendance at the hospital and jail. The Los Angeles Herald understood the doctor’s motives: “He was a stranger here, and the position of hospital physician would be a good advertisement for him, by which

255 “Evening Republican,” 18 February 1875,” in Ibid. Despite a diligent search, no original copies of this issue could be located, either in hard copy or on microfilm.

256 “Grand Jury Report,” Los Angeles Star, 15 January 1870; “Minutes, 6 April 1874; 7 April 1874; 8 April 1874”; “Minutes, 8 April 1874; 6 May 1874,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.

257 “Grand Jury Report,” Ibid.

258 “Llamamos la atención del Concilio Comun y Junta de Supervisores hacia el credito gasto de manejar el hospital bajo el plan actual y recomendamos muy encarecidamente a dichos cuerpos que separadamente o de mancomun den providencias para fundar un hospital que pertenezca al Condado o a la ciudad y condado.” “Informe Del Gran Jurado,” La Cronica, 29 September 1875.
Brooke’s strategy for attracting patients apparently worked, since he built such a large practice by the end of 1875 that he no longer had time to care for county patients—at least at that price. Despite understanding Brooke’s motivations, the Herald did not excuse him from neglecting county patients: “Dr. Brooke knew before he bid the pitiful sum of $40 per month what he would have to do at the hospital as well as he does now. We presume he is a regular graduate and if he is, he did not go into this ‘bad job’ blindly.” Brooke’s neglect of county patients probably contributed to complaints raised to the grand jury in 1875. Slow delivery of medicines may have resulted from Brooke’s irregular attendance at the hospital. The sister-nurses could not write prescriptions, but, the patients—and Grand Jury—probably never understood that. Since they were onsite, the sisters were held responsible.

Although Brooke resigned, public criticism continued to emanate from the Grand Jury inspections during 1876. In their November report, they noted the hospital was clean, but protested that attendants neglected patients at night: “there is great complaint among the patients, of them being utterly helpless, and suffering intensely during the long nights for the lack of water, and other attention, and before morning the whole ward becomes foul with sickening odors. This, together with their piteous cries for help, breaks the rest of all in the room, consequently all are damaged by it.” The sisters preferred to hire a male night nurse, both to attend patients and provide security, but the county refused to pay his salary. In this case, the county appeared to be taking advantage of the sisters’ free labor. After Dr. Brooke resigned, the supervisors passed an ordinance that raised the county physician’s salary to $1000 per year, more than doubling the 1875 contract. At the same time, they continued to pressure the sisters to cut their costs and eliminated the salary for a night nurse. Even though they did not take a salary, the sisters required reasonable accommodations for themselves and their patients. A night nurse’s salary was very little when compared to the value of the sisters’ services, but the supervisors forgot this when dealing with the bottom line.

Even though there are no surviving records of the sisters pointing out the economic value of their contributed services, the Daughters of Charity refused to take the blame for the county’s negligence in 1876. When the Grand Jury asked the sisters to hire a night nurse, “They informed us that they had one until a short time since, when the Supervisors told them that the County could not bear so much expense.” To avoid additional bad press, the sisters made sure the Grand Jury accurately understood the reasons for patients’ complaints and publicly assigned responsibility for the problem to county leaders, probably in an attempt to pressure the supervisors to restore funding for the night nurse’s salary. The Grand Jury included the sisters’ comments in their report, but instead of reprimanding the county, the spokesman ended up chiding the sisters for failing to secure a written contract with the Board of Supervisors. Since the night nurse’s salary was not guaranteed in writing, then nothing obligated the county to continue to pay him. Noting that “this whole business has been transacted for years upon verbal contracts, if there is any contract at all,” the report implied that the sisters’ hospital was a frontier relic and recommended the county move forward with efforts to build a new hospital.

Unfortunately, these press reports do not reveal the timing or motive for such actions. Did the supervisors eliminate the night nurse’s funding a day or two before the Grand Jury’s inspection to embarrass the sisters and bolster their argument for construction of a new hospital? Perhaps. The supervisors failed in their 1876 attempt to gain state approval for the construction of a new hospital, and they may have wanted more ammunition for their lobbying efforts in the next legislative session. It is more likely, however, that the supervisors were desperately trying to stop the bleeding from the hemorrhaging hospital fund. The number of patients had skyrocketed since 1874, nearly doubling in 1875 and increasing by another 26 percent in 1876. In the third quarter of 1876 alone, 110 patients were admitted to the Los Angeles Infirmary, while fifty-four patients resided there on the day of the Grand Jury’s visit. Economic conditions, coupled with a steady stream of destitute health-seekers and a diphtheria epidemic, explain the spike in the number of charity patients and the county’s rising costs.

The heavy patient load not only affected the budget, it also stretched the sisters’ capacities. Barring any incidental travel or illness, nine Daughters of Charity served at the Los Angeles Infirmary in November 1876. Sister Ann

259 “County Hospital Physician,” Los Angeles Herald, 12 February 1876.
260 Ibid.
262 The Board also changed the physician’s method of appointment: supervisors voted for the county physician, rather than accepting the lowest bidder. Martin, History of the LA County Hospital, 12; “Minutes, 9 February 1876; 3 April 1876.”
264 Ibid.
265 Two hundred thirty patients were treated at the hospital in 1874, 426 in 1875, and 579 in 1876. See table 4.1.
Gillen and her protégé Sister Mary Stella Boyle were very experienced nurses. Gillen had more than twenty-five years of experience, and Boyle had fifteen. But five of the nine sisters had been at the hospital for one year or less. It is unclear whether or not Sisters Annina Reilly, Guadalupe Quirivan, and Felicitas Gonzales had any nurses’ training before coming to Los Angeles. They may have been assigned cooking, cleaning, laundry management, or administrative duties. That left six nurses, with varying levels of experience, to care for, on average, forty-eight patients per month.\(^268\) Employing a night nurse would have been the most efficient way to maximize the time and energy of the sister-nurses. Caught flatfooted by the county’s withdrawal of funding, Sister Ann would have needed to rearrange the workload among the sister-nurses, and possibly provide additional training, before they would be prepared to cover the night shift. Given the heavy demands on the sisters, she probably hoped the county would restore the position. Nevertheless, it seems unlikely that the Daughters of Charity would leave patients unattended for weeks on end.\(^269\) Although

\(^{268}\) Originally from Santa Cruz, California, Sister Mary Stella Boyle (1843–1906) joined the Daughters of Charity in 1861, and received her seminary training in Los Angeles. Likely trained as a nurse by Sister Ann Gillen, Boyle spent most of her career at the Los Angeles Infirmary, 1861–1881 and 1883–1887. Sisters Guadalupe Quirivan (b. 1832), Maria Chavez (b. 1835), and Felicitas Gonzales (b. 1836), were sent to Los Angeles after the Mexican government exiled the Daughters of Charity and other communities of women religious in 1875. Chavez was a postulant at St. John Hospital of God in 1856, so it is plausible that she was a trained nurse. Quirivan was a postulant at St. Christopher’s Infant’s Asylum in Puebla, so she may or may not have had nursing experience. Gonzales’s nursing experience is also unknown, but she was only assigned to the Los Angeles Infirmary for eight months (April 1876–January 1877), so her skill set may not have been a good match for the institution. Sister Annina Reilly (1850–1881) joined the Daughters in 1873; she was the secretary for the Los Angeles Infirmary from August 1875–October 1880, and may not have had much nursing experience. Robertine McKinnon (b. 1845) joined the community in 1870, and was one of the last sisters to receive her nursing training in Los Angeles. Sister Ann Gillen probably trained her as a nurse, and McKinnon may have worked at both the orphanage and hospital before being assigned to the hospital full-time in 1874. Sisters Eugenia Sullivan (b. 1856) and Mary Thomas Murphy (b. 1843) were postulants at Mount Hope, and they may have received some introductory nurses’ training before coming to Los Angeles. But both women were relatively new to the community: Murphy joined in 1874, Sullivan in 1875. At age twenty, Sullivan had only been at the hospital for six months, and it is unlikely that either Murphy or Sullivan would be left on their own oversight. “Ann Gillen, D.C., “Mary Stella Boyle, D.C., “Guadalupe Quirivan, D.C., “Maria Chavez, D.C.,,” entries in Daughters of Charity Consolidated Databases (10-0), APSL. Minutes, 1874–1887, Corporation Book, 1869–1909, SVMCHC, Los Angeles. “Register, Catalogue Du Personnel—États-Unis,” n.d., Archives of the Daughters of Charity, Paris. Copy consulted at SVMCHC, Los Angeles, 2007.

\(^{269}\) “Particular Rules for the Sisters in Hôtels-Dieu and Hospitals” established a series of standard procedures for Daughters of Charity who nursed patients overnight. Considering the “service they render the sick is a continual prayer before God,” the sisters were charged with providing comfort and spiritual consolation to the sick, particularly those who were near death. “Particular Rules for the Sisters in the Hôtels-Dieu and Hospitals: Means the Daughters of Charity Will Use to Carry Out Their Duties in the Hôtels-Dieu and Hospitals,” CCD, 13b:193; “Particular Rules for the Sisters in the Hôtels-Dieu and Hospitals: Advice for the Night Nurses,” Ibid., 199-200 In addition, the 1812 not reported in the press, the issue was probably resolved within days.

**Scientific Charity and a New County Hospital**

Nationally, the Panic of 1873 heightened calls for reform in American social welfare practices. The “scientific charity” movement stressed the potential moral degradation of indiscriminate almsgiving and urged counties to reduce direct distribution of food, coal, or cash to impoverished families, a system known as outdoor relief. Advocates also encouraged officials to require poorhouse residents to work for their aid. Josephine Shaw Lowell and other reformers also sought to institute rational, scientific management of welfare institutions. As they studied the problem, organized possible solutions, and encouraged cooperation among interested parties, reformers believed that they could develop more efficient, humane welfare institutions at lower cost. “Scientific” institutions discouraged perpetual dependence by separating young “reformable” inmates from the potential moral corruption of incorrigible paupers, and through requiring able-bodied inmates to work for their aid. Despite their rational approach to the problems of poverty, reformers rarely disentangled themselves from the religious and ethnic biases often ingrained into charitable relief efforts. The scientific charity movement had anti-Catholic undertones and challenged the authority, expertise, and traditions of religious communities like the Daughters of Charity.\(^270\)

Scientific charity also influenced hospital reform during the 1870s. In *Hospitals: Their History, Organization, and Construction* (1877), Dr. W. Gill Wylie comments on the social necessity of hospitals and promotes improved sanitation, management, and architectural design to reduce the incidence of hospital-born disease. As a member of the New York State Board of Charities, Wylie worked with Regulations for the Sisters of Charity instructed sisters to “never let them [the sick poor] suffer for want of giving them the necessary assistance, medicine, etc. at the exact time and in a proper manner.” “The Rule of 1812, Regulations for the Society of Sisters of Charity in the United States of America,” in Kelly, *Numerous Choirs*, vol. 1, 253. A sister who served at the New Orleans Marine Hospital during the Civil War exemplifies the concern that sister-nurses had for their patients, particularly at night: “Our greatest pain was, that while we were away from the patients during the night many would die, and no one to whisper a word of consolation to them, or excite them to sorrow for their sins. It seemed as if they died faster during the change of atmosphere at night, than during the day — It was very afflicting to enter the ward in the morning with the hope of administering comfort to some patient we left quite weak in the evening—and find their cot occupied by another, or their place on the hard floor vacant.” “Notes concerning the Marine Hospital in New Orleans,” *Notes on the War Between the States* (unpublished manuscript, APSL), 330. If no other assistance was available, the Los Angeles sisters would have been taught that it was their religious duty to care for the sick and dying at night. The lack of night attendance was likely resolved as quickly as possible. My thanks to Betty Ann McNeil, D.C., who directed me to these sources, and provided the excerpt from the above manuscript in the Emmitsburg archives.

Josephine Shaw Lowell, and his writings illustrate the influence of the movement she came to represent. Although admitting that hospitals were necessary to provide for sick “paupers without any homes,” he claimed that free medical care was so widely available in New York’s free dispensaries and hospitals, “that the poor have no necessity to make provision for sickness, nor any inducement to guard against disease, and so avoid the trouble and expense incident to sickness.”

Free care discouraged self-reliance, undermined self-respect, and acted as “the first stepping-stones to the degradation of pauperism.” In addition, Wylie contended that “pauper hospitals” discouraged family responsibility for sick and elderly relatives, exposed individuals to “bad influences,” and “foster[ed] idleness, helplessness, and their natural results, pauperism and crime.” To make matters worse, Wylie argued, poorly designed and managed hospitals became “centres of infection, thus defeating the very object they are intended to promote.”

Wylie proposed a series of social, organizational, and architectural improvements to address deficiencies in American hospitals. Architecturally, Wylie promoted a version of Florence Nightingale’s “pavilion plan.” He indicated that, whenever possible, hospitals should be placed on large country lots “to give the patients the advantage of pure air.” Like Nightingale, Wylie stressed the importance of relatively small, separate wards, with good ventilation. He recommended hiring managers, nurses and housekeepers of good character, who rigorously maintained a clean, efficient, and sanitary hospital. Efficient construction and management could reduce the length of hospital stays, and in turn, reduce long-term costs. As to a hospital’s social mission to reduce “pauperism,” Wylie suggested that administrators investigate individual cases to determine financial need, foster a sense of personal responsibility among charity recipients, and “limit hospital accommodations to those who have no homes and to those who cannot be assisted at their homes.” His recommendations reflect the scientific charity movement’s emphasis on individual responsibility, and its suspicion that the poor took advantage of the system. However, Wylie also supported proactive reforms to ensure public health, including educating the poor on preventing disease, improving tenement housing conditions, outlawing the sale of tainted food, and instituting measures to prevent smoke and fumes from disrupting the “pure air” inside the hospital.

In New York, Lowell and her colleagues used the arguments proffered by scientific charity as a method to fight the political corruption of Tammany Hall, known for freely distributing relief in exchange for votes. William “Boss” Tweed’s support for Catholic charities also gave scientific charity an anti-Catholic bent, although religious biases do not appear prominently in the Los Angeles debate. However, concepts of individual responsibility, working for aid, and economic efficiency significantly influenced the county’s justification to build a County Hospital and Farm.

In her *History of Los Angeles County Hospital* (1978), Helen Eastman Martin asserts that the Board of Supervisors bowed to increasing pressure from physicians, citizens, and Grand Juries to establish a new County Hospital and Farm. These pressures, brought to bear between 1871 and 1877, focused on cost: the increasing numbers of patients that led to higher taxes, the higher cost of indigent care in Los Angeles versus San Francisco, and the hope that patient’s work on a county farm could reduce food costs, thereby further reducing county expenses. The County Farm more closely mirrored an eastern poorhouse, which diverged from the model developed by the Daughters of Charity.

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272 Ibid., 60.
273 Ibid., 65–66.
274 Ibid., 66.
275 Ibid., 90.
276 Ibid., 67.
277 Ibid., 67–68.
278 A copy of Wylie’s work was in the Barlow Library, a predecessor to the Los Angeles County Medical Association Library. LACMA’s library is now part of the rare books collection at the Huntington Library. Martin, *History of the LA County Hospital*, 21–22.
280 Martin, *History of the LA County Hospital*, 16.
COST VERSUS CARE: THE POLITICAL DEBATE SURROUNDING INDIGENT CARE IN LOS ANGELES

Throughout the 1870s, the County Board of Supervisors experimented with several strategies to manage its social welfare costs. Two years after being rebuffed by the state legislature, Los Angeles county physician Dr. Henry S. Orme proposed that the supervisors lobby the legislature to build an “Alms House or Branch State Hospital” to care for the “comparative strangers” filling up the county’s hospital beds. Almshouses remained attractive because of the romanticized assertion they “could be, in part, made self-sustaining.”281 Orme’s support for an almshouse represents a new strategy to garner state funding, particularly since the state had authorized almshouse hospitals and farms in San Francisco and Sacramento in the late 1860s. The First Biennial Report of the State Board of Health of California (1871) praised the eighty-acre Almshouse of San Francisco and claimed its fields “supply the institution with nearly everything required for food.”282 The Sacramento County Board of Supervisors also found the hospital farm attractive, and they built a new facility three miles from town despite the protests of area physicians that the plan was “erroneous and impracticable.”283 The physicians argued the farm’s country location would increase transportation costs for goods and medicine, delay treatment, exacerbate injuries for patients who had to travel there from the city, and decrease accessibility to the hospital for out-patients, visitors, and physicians.284 The State Board of Health reinforced these arguments in its 1871 report, claiming “the whole institution is a willful blunder.”285 Nevertheless, Los Angeles made a concerted effort to construct a county hospital and farm for the next six years.

In part, scientific charity shaped these efforts to establish hospital farms. Although Lowell excoriated the deplorable conditions in New York’s poorhouses, California’s hospital farms would be new, modern facilities, designed to take advantage of the countryside’s “pure air.” Adding a farm offered the promise of self-sufficiency while encouraging individual responsibility. Inmates would work to subsidize the cost of their care. Proponents stressed efficient management and attention to scientific methods—hallmarks of the scientific charity movement. Hospital farms proved to be politically attractive, salving humanitarian impulses of the citizenry without fostering dependence. However, hospital farms did not immediately reduce county welfare costs. Sacramento’s hospital farm cost an estimated $90,000, and since patients were discharged as soon as they were able to work, physicians believed that few inmates would be available to perform farm labor.286 Thus, while such farms represented scientific charity’s emphasis on humane, efficient institutions, in practice the cost savings rarely materialized.

In Los Angeles, the hospital farm concept attracted the support of politicians, boosters, and physicians. Beginning in September 1876, the Board of Supervisors experienced a sharp increase in petitions for indigent relief. Submitted primarily by poor women and their families, these individuals requested (and received) allotments between ten and twenty-five dollars per month.287 Likely brought on by the lingering effects of the depression and smallpox epidemics, this increased demand for public relief dovetailed with the supervisors’ interest in establishing an almshouse and hospital. In addition, a hospital farm would meet the needs of the growing medical community. With a larger facility and more patients, physicians could institute a medical training program. The county hospital would offer clinical experience to students, an essential pre-condition of establishing the University of Southern California’s College of Medicine in 1885.

Boosters constantly compared Los Angeles to San Francisco and eastern cities. Building schools, hospitals, and churches increased the city’s desirability to middle-class migrants. Shortly after the sisters took over the pest house in 1877, the Grand Jury reported that the facilities at the Los Angeles Infirmary were “not suited for the purposes of a hospital in a city of our magnitude and importance.”288 Although they did not criticize the sisters’ nursing care, the Grand Jury recommended that “the proper authorities shall devise some way

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281 “Board of Supervisors: Hospital Report,” Los Angeles Star, 3 December 1872.
283 “Petition of the Citizens of Sacramento in Relation to the Erection of a Hospital in Sacramento County,” in Appendix to Journals of Senate and Assembly of the 18th Session of the Legislature of the State of California, 1870, Volume 3 (Sacramento: D.W. Gelwicks, State Printer, 1870).
284 Ibid.
285 First Biennial Report, 41.
286 Ibid.; “Petition of the Citizens of Sacramento in Relation to the Erection of a Hospital in Sacramento County.”
287 Prior to September 1876, the minutes of the Board of Supervisors rarely contained petitions, much less approvals, for poverty relief. However, between the fall of 1876 and the spring of 1878, approximately thirty individuals or families applied for relief, and some individuals applied several times. Most requests were for monthly maintenance, but others were to pay travel costs to assist the sick return home, or to pay guardians and nurses (perhaps to care for insane individuals). Most requests were for single/widowed women with or without children, but in a few cases men also received relief. “Minutes, 6 September 1876; 2 January 1877; 4 January 1877; 5 April 1877; 10 May 1877; 3 July 1877; 10 September 1877; 14 September 1877; 6 November 1877; 8 November 1877; 3 December, 1877; 4 December 1877; 14 December 1877; 7 January 1878; 9 January 1878; 10 January 1878; 4 February 1878; 8 February 1878; 5 March 1878; 6 March 1878; 7 March 1878; 2 April 1878; 3 April 1878; 6 May 1878,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.
of erecting a suitable hospital in the city or suburbs.”289 In listening to these recommendations, the supervisors extended their political support with boosters and physicians, and could campaign on the platform of improving county facilities while reducing long-term costs. At the time, a county farm made sense to everyone that mattered—everyone except the Daughters of Charity.

The political discourse surrounding the hospital focused on cost, not care. Citing a report from the San Francisco Alms House and Branch Hospital, the Grand Jury reported that Los Angeles spent $1.04 ½ cents more per day caring for the indigent sick than did their northern rival: including medicine and physician costs, Los Angeles spent $1.22 per patient per day, while San Francisco spent 17 ½ cents per day.290 The Republican picked up the fight and argued that Los Angeles County was paying too much for its hospital services: “It is not a very gratifying fact to the tax-payers of this County that it is costing us very much more to maintain our indigent sick in the Sisters’ Hospital in this city than it does in any other County in this State. We have in our possession the statistics of the cost in several prominent counties, and none of them are within half as high as our own.”291 The Republican cited a San Francisco report in which food costs were 14 ½ cents per day, while subsistence costs in Los Angeles county were 75 cents per day. To be fair, these charges do not fully account for the differences between an almshouse and a hospital. The sisters provided patients with shelter, heat, clothing, bedding, bandages, and food, so comparing the maintenance costs of the Los Angeles Infirmary with just the food costs of the San Francisco Almshouse was inaccurate and underhanded.

However, the Republican’s comments highlight the suspicion that the Daughters of Charity cared for the poor “too well.” By supposedly encouraging dependence and fostering inefficiency the sisters committed mortal sins according to scientific charity advocates. What made matters worse, from the editor’s point of view, was the implication that sisters were inflexible and unwilling to change: “The unpleasant feature of this business is that there is no prospect of a diminution in the cost until we have established a hospital farm by the summer of 1877. It appeared to be inevitable.

In light of the sisters’ heroic efforts during the smallpox epidemic, no one could criticize the sisters’ nursing abilities. The sister’s rules mandated cleanliness and compassion, adequate food and medicine, and attentive nursing and regular medical attendance. As Daughters of Charity, the sisters prioritized the spiritual and physical comfort of their patients, and this philosophy demanded a minimum standard of care. While this was appreciated during smallpox epidemics, the ongoing suspicion of the poor as social parasites fostered resentment, especially if it appeared they were too comfortable. Unlike reformers who worried over the effects of charity on a recipient’s character, the sisters were much more likely to give freely and give often—going against the grain of social welfare trends in the 1870s.

Comparing the Los Angeles Infirmary with the San Francisco Almshouse proved to be the most powerful rhetorical device in getting the county to act. Claims of San Francisco’s economic efficiency went unanalyzed, and they were probably used to further pressure the sisters to reduce their contract rates. In February 1877, a patient wrote a letter opposing the hospital farm to the Express. Highlighting the fallacy of believing that hospital patients could perform farm labor, he explains, “Allow me to say that there are none here who can do light work, and the Doctor came near to discharging me because he observed me peeling potatoes for the Sisters…. I know that drones are not tolerated here, and know, too, that as soon as a man can do ‘light work’ he has to ‘take a walk,’ as the patients facetiously term a discharge.”293 Unfortunately, the letter appears to have done little to sway public opinion, and neither the Spanish or English newspapers expressed any opposition to the hospital farm by the summer of 1877. It appeared to be inevitable.

Although proponents successfully garnered local support for the new venture, legislative maneuvers caused delays in the construction of the Los Angeles County Hospital and Farm. The legislature had approved $16,000 in bonds during the year 1874, but rising land prices prevented the county from obtaining a suitable tract within city limits, as required by law.294 The county submitted a proposed amendment to this measure in 1876, but it was tabled and the bill was again postponed in 1877. The legislature finally approved the sale of $25,000 in hospital bonds in early 1878. On 22 May 1878, the Board of Supervisors bought thirty acres of land from Dr. John S. Griffin for the purpose

289 Ibid.
291 “A County Poor Farm,” Daily Republican, 19 July 1877.
292 Ibid.
293 “Hospitals and Poor Farm,” Los Angeles Evening Express, 10 February 1876.
294 In response to concerns expressed by Sacramento physicians regarding the drawbacks of getting to a county hospital for patients, physicians, suppliers, and employees, in 1874 the legislature mandated that county hospitals be placed within the city’s corporate limits. Land prices and neighbor opposition prevented the county from constructing a new hospital at that time. See “A Hospital Farm,” Los Angeles Evening Express, 9 February 1876; “Petition of the Citizens of Sacramento in Relation to the Erection of a Hospital in Sacramento County.”
of constructing a County Hospital and Poor Farm. Although the sale of Dr. Griffin’s land could be interpreted as “just business,” it shows that he likely supported the county hospital. As Griffin had known and worked with the Daughters of Charity for twenty years, this may have been a bitter pill to swallow.

Financially, losing the county contract was disastrous for the Los Angeles Infirmary as it represented a huge portion of the sisters’ receipts. Losing that income nearly put them out of business. On 4 November 1878, the board authorized the transfer of forty-seven charity patients to the hospital on Mission Road, and they refused to pay for any indigent patients treated outside the new facility. Without a steady source of income, the Daughters of Charity were forced to scale back their services, admitting only 107 patients in 1879, only 18 percent of the number admitted three years before (table 4.1). Receipts also dropped from $20,000 in 1877 to only $7500 in 1881 (table 4.2). The sisters would not begin to recover financially until the real estate boom spurred growth in 1883.

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295 “Board of Supervisors,” Morning Republican, 24 May 1878; Martin, History of the LA County Hospital, 17-18; “Minutes, 7 May 1878; 8 May 1878; 9 May 1878; 10 May 1878,” Book 6 (July 1873-10 May 1878), Historical Board Minutes, Box 3, LACBS, Los Angeles.

296 Statistics calculated from a random sample of patient records between 1872 and 1878, the earliest admissions book available. Of the 476 patients in the sample, there were 375 charity patients, 95 private patients, and six unknown. Although more may have been treated, the sisters recorded 2154 patient admissions between 1872 and 1878. “Hospital Admissions Book, December 1872-1896.” See Appendix B for sampling method. Patient counts come from the raw number of entries in the admission book (no sampling). The patient count in 1879 represents a dramatic drop, considering the sisters admitted 579 patients in 1876. The purchase of Griffin’s land was discussed in early May 1878. See “Minutes, 7 May 1878; 8 May 1878; 9 May 1878; 10 May 1878.” The authorization for patient transfers was recorded in “Minutes, 4 November 1878,” Book 7 (16 May 1878-13 July 1882), Historical Board Minutes, Box 4, LACBS, Los Angeles. Helen Martin reports that 47 patients were transferred to the new hospital. Martin, History of the LA County Hospital, 22.


The separation of Sisters’ Hospital and County Hospital marked a key transition in social welfare services in Los Angeles. To boosters, physicians, and politicians, the new County Hospital could be interpreted as part of the “Americanization” of Los Angeles. Freed from its Catholic (Mexican) past, the new County Hospital shed sectarianism and firmly placed the county as an agent of modernization. In discussions of the time, it was easy to forget the city’s first hospital was started by American Catholics, and that it served the entire community on a non-sectarian basis. Moving the County Hospital out of town also allowed residents to segregate the “foreign” element of the population. The hospital primarily served working-class Americans, Irish immigrants, and Mexicans. Jewish and Christian concepts of charity demanded that Angelenos care for “suffering humanity,” but placing them outside the city limits seemed a little safer. In the 1870s, Angelenos still believed that health-seekers were good for the economy, and a way to grow the city; they just wanted them to be self-supporting. Yet there is also a racial aspect which further complicated the development of the hospital. The smallpox epidemic of 1877 became racialized when Mexicans and Chinese were blamed as sources of disease. While all public discussions about establishing the new County Hospital focused on cost, race and class biases certainly influenced discussions about what was worth paying for.

The “foreign” element has to be placed in tension with desires for modernization and legitimacy among Los Angeles businessmen and politicians. Efforts to build the Hospital Farm ensued during boosters’ efforts to induce the Southern Pacific Railroad to make Los Angeles its western terminus. The railroad would increase business and immigration, but it would also increase demand on county social services. The county had to demonstrate it was prepared...
to meet these demands as a “modern” city but also find a way to manage its costs, making the farm even more attractive. The depression in 1875-1876, and the 1877 smallpox epidemic, magnified the need for these services. Physicians would also support the development of an independent county hospital as an avenue for greater professional opportunities. County Hospital represented an opportunity to have greater influence in medical affairs, the hope for opportunities to advance scientific research, and a long-range opportunity to train medical students with government support. For the Board of Supervisors, the Hospital Farm offered a vain promise of self-sufficiency, even though it cost more in the short run.

But what about the sisters? The Daughters of Charity had developed a twenty-year relationship with Los Angeles County officials. They served the city during smallpox epidemics and faithfully cared for the indigent sick for two decades. Time and again, the sisters had compromised with the county, accepting reductions in fees in order to maintain their service to individuals in most desperate need. Caught up in their own struggles for control, few politicians or physicians openly recognized sister-nurses as trained professionals. Despite their knowledge and experience, the Daughters were seen as charitable caretakers of the poor, subservient and self-sacrificing women who donated their time. In many ways this was the image that the sisters were trained to cultivate in the public mind. But, it also backfired on them occasionally, leaving them open to be forgotten, less important than the doctors, and easier to take advantage of. Despite this, the Daughters of Charity creatively managed to do more with less, to provide comfort and care for the sick, and to accomplish their mission to extend charity to those struggling in poverty.

THE SISTERS’ PERSPECTIVE

The sisters’ records are remarkably silent on their separation with the county. Tragically, Sister Ann Gillen’s letters to Emmitsburg were lost, and the minute books never mention concerns about the contract or the development of a new county hospital. In the absence of a clear documentary record, historians are left to speculate about the attitudes and reactions of the sisters. Oral tradition holds that the sisters opposed the hospital farm model, refused to compromise patient care by further reducing their rates, and chose to sever their ties with the county, trusting in Providence to provide a way for the sisters to continue their mission to provide health care to the sick poor. Emphasizing agency, autonomy, and faith, this tradition teaches contemporary Daughters of Charity the community’s approach to overcoming seemingly insurmountable obstacles. Considering the history of the Daughters, this interpretation has merit. Their centralized structure provides some clues about possible institutional responses to conflicts, disagreements, or opposing strategies. Learning how sisters responded to similar situations over their history provides clues to the sisters’ likely responses in dealing with events in Los Angeles.

Throughout the nineteenth century, the Daughters of Charity tended to withdraw from situations that threatened their autonomy, contradicted their rules, or challenged their ability to effectively serve poor individuals or their families. In the second volume of *Numerous Choirs* (1996), Ellin M. Kelly compiles a year-by-year account of the community’s activities from letters, minutes, and other archival sources housed in the collections of each of the American provinces. Covering the years between Elizabeth Bayley Seton’s death and the Civil War, Kelly pays particular attention to letters that note the establishment of new institutions or the withdrawal of sisters from particular locations. Before 1850, the Sisters of Charity withdrew from institutions for both practical and religious purposes. The Emmitsburg Council withdrew sisters because daily religious services, such as mass, were not available or because other communities duplicated their services. In 1841, the sisters left St. Joseph’s School in Martinsburg, Virginia. Although they had operated the school for nearly four years, they decided that the school catered too much to the needs of wealthy students. Many parishes needed schools for poor children, and the sisters decided they could better fulfill their mission elsewhere.298 Throughout their history, the sisters periodically evaluated their services in light of their primary mission to the poor, expanding or contracting to meet the mission of their religious community and the people they served.

In their hospital work, the sisters sought to preserve their autonomy within collaborative efforts. At times, they chose to dissolve a partnership because of a previously unforeseen opportunity. In 1862, the council withdrew sisters from the Baltimore Infirmary because Charles Dougherty offered to construct a new hospital on property donated by Lady Elizabeth Stafford, granddaughter of Charles Carroll. The sisters had staffed the Baltimore Infirmary (later University Hospital) since 1823, but the opportunity to establish a hospital specifically for the sick poor (and at the request of the Archbishop of Baltimore Francis P. Kenrick) convinced them to make the change.299

While opportunity encouraged the sisters to start new ventures, sometimes the Sisters of Charity dissolved partnerships over disagreements about working conditions. In 1840, the Sisters of Charity withdrew from Maryland Hospital, sometimes referred to as the Maryland Hospital for the Insane. Founded in 1828 by Dr. Richard S. Steuart, the Sisters of Charity agreed to staff the institution after the cholera epidemic in 1833. Although initially free to manage the hospital


according to their rules, historian Daniel Hannefin explains that differences arose between the sisters, physicians, and the board of managers in 1840, particularly over patients leaving the hospital at night without permission. This behavior contradicted the sisters’ rules. The board then instituted new guidelines which limited the sisters’ authority. Feeling like servants or “slaves,” they decided to leave the institution. Taking eighteen patients with them, the Sisters of Charity founded Mount Saint Vincent’s, a new hospital for the mentally ill. In 1842, the sisters hired one of Maryland Hospital’s administrators, William H. Stokes. They bought more property from Mount Hope College in 1846, and opened both a general hospital and facility for treating the mentally ill at the new site. Under the sisters’ management, Mount Hope developed a national reputation for care of the insane, and they continued to operate the facility well into the twentieth century. Mount Hope demonstrates the choice of sisters maintaining their autonomy, keeping their rules, and taking financial risks in hopes that Providence would bless them with means to continue their mission. Perhaps, the Los Angeles sisters also hoped that in their situation they too would be rewarded for standing firm in their beliefs.

Another telling example of the sisters’ willingness to take financial risks in efforts to maintain their autonomy occurred in Buffalo, New York. The Sisters of Charity opened their Buffalo Hospital in 1848. Although initially receiving public funding, the sisters reached out to private patients and established relationships with a local medical school. As the medical profession changed, doctors became more important relative to the hospital by the 1890s. However, Jean Richardson demonstrates that the sisters retained control of the institution by holding all board positions, appointing sister-administrators, and supervising all nurses and other employees. In 1898, Sister Florence O’Hara decided to restructure the hospital organization to include more specialized departments. Senior medical faculty opposed this move because it would weaken their influence in the hospital and reduce the number of beds for their patients. When Sister Florence went ahead with the changes, the senior medical staff resigned and took their medical students with them. Much to their surprise, the sisters accepted their resignations and Sister Florence continued the reorganization using younger, more supportive physicians. As a result of this controversy, senior medical faculty lost both their appointments at the sisters’ hospital and their clinical facility, essentials to attract students, maintain the medical school’s charter, and allow students to graduate. Sister Florence called their bluff and continued to direct the hospital as she saw fit. In much the same way, the Los Angeles sisters may have chosen to dissolve their partnership to free themselves of county politics, retaining power to guide and direct their work.

CONCLUSION

In the 1870s, the political and cultural currents that shaped the development of professional medicine in Los Angeles ran contrary to some of the established traditions of the Daughters of Charity. Promoters of the hospital farm conflated the scientific benefits of a “modern” medical facility with the traditional structure of a poorhouse. By ending their partnership with the county, the Daughters took a stand against a system that rarely treated the poor with compassion and respect. However, the sisters also lost their position as primary service providers for the sick poor in Los Angeles. When they treated county-funded charity patients, the Daughters directly influenced the delivery of healthcare services for the indigent sick. But by shifting their efforts to the private medical marketplace, the sisters lost their control over the quality of public health services. The Daughters of Charity needed to find an alternative route if they wanted to continue their mission.

During the early 1880s, the sisters in Los Angeles underwent a period

300 Hannefin, Ibid., 55-58, 75-76; Kelly, Ibid., 103; James A. Steuart, “Dr. Richard Sprigg Steuart and the Maryland Hospital for the Insane,” Maryland Medical Journal 35:26 (1897), 459.

301 Richardson, A History of the Sisters of Charity Hospital, Buffalo, 145-152.
of reorganization. Sisters Guadalupe Quirivan and María Chavez were transferred to Guayaquil, Ecuador, in 1880. Sister Ann Gillen, the hospital's first administrator and president of the hospital corporation, was reassigned near the end of 1881. Sister Ann served briefly in Emmitsburg, and later went to St. Joseph's Hospital in Philadelphia, where she worked from 1884 to 1892. The Emmitsburg Council transferred Sister Emily Conway (1845-1920) from Mt. Saint Joseph's Infant Asylum in San Francisco, and she took over as sister servant and president of the hospital corporation in early 1882. New leadership, and more importantly, changing economic conditions, allowed the sisters to recover financially and the hospital started to grow again that year. Under Sister Emily's direction, the Daughters of Charity built a new hospital on Sunset Boulevard and Beaudry Avenue. Although still officially named the Los Angeles Infirmary, city residents commonly referred to the institution as Sisters' Hospital. During the 1880s and 1890s, the sisters treated health-seekers, railroad workers, and sailors. Reshaping their mission to meet changing conditions, the Daughters of Charity sought to maintain their connection with working-class Angelenos and to continue to provide spiritual and physical comfort to the sick poor.

While the consequences of urbanization created difficulties for the Daughters of Charity in the 1870s, the real estate boom in the early 1880s also provided new opportunities. Easy rail access brought thousands of migrants to the city, raising property values. When the Southern Pacific opened its new rail depot across from the sister's hospital in 1877, the noise, soot, and traffic threatened the hospital's reputation as a “healthful place.” Although, several years later inflated property values provided the capital necessary for the sisters to purchase more land and build a new hospital. Additionally, the three hundred railroad workers employed in Los Angeles county needed medical care, and nearly a third of them lived within walking distance of the Los Angeles Infirmary. Racial discrimination, poor housing, and continual economic stress contributed to a need for health care within the California and Mexican immigrant communities, a need that the Daughters could not easily ignore.

By building a new facility, the Daughters of Charity sought to maintain their historic position in—and their continued relevance to—the medical community in Los Angeles. In the 1870s, the efforts of physicians, boosters, and politicians to found a new county hospital suggest that these power players no longer saw the Daughters as assets in constructing their vision of a modern city. Clothed in their blue habits and cornettes, the sister-nurses looked decidedly “un-modern,” and their focus on community and traditions of holistic healing ran contrary to the individualistic, career-oriented ethos that accompanied physicians’ embrace of scientific medicine. While the Daughters of Charity did not oppose improvements in the diagnosis and treatment of patients, they did not operate the Los Angeles Infirmary for the benefit of physicians. This position could easily be misinterpreted as a resistance to scientific medicine, a prospect with which physicians and boosters alike pinned the city’s economic hopes.
workshops,” and surgeons, in particular, promoted hospitals as sites to treat acute, but curable, conditions rather than chronic illness. Rosenberg admits that physicians’ influence remained powerful, but he emphasizes the economic realities that shaped the development of hospital services. As government subsidies diminished and charity resources became overextended, hospitals looked to private patients to make ends meet. By the 1920s, hospitals even redesigned their physical plants to accommodate middle-class paying patients with semiprivate rooms, thereby providing acceptable facilities for patients of all classes.310 In the early twentieth century, hospital services remained capital intensive, and older institutions had to adjust their organizational structures to remain competitive.

These changes pushed religious hospitals to reshape their charitable mission somewhat. Paul Starr argues that nineteenth-century religious hospitals, particularly Catholic institutions, developed as a response to religious competition and prejudice in the United States. Catholics worried that they might not receive their last rites, and leaders feared “efforts might be made to convert some of their members in moments of personal crisis.”311 Spiritual matters remained important in the early twentieth century, but Catholic hospitals also served as vehicles for professional mobility. Catholic medical students, physicians, and administrators found positions within these hospitals when other opportunities were often closed to them. Starr claims that denominational hospitals acted as buffers against discrimination for patients and professionals, and this function reinforced the perceived need to maintain Catholic hospitals throughout the country.

But financially, Catholic hospitals had to readjust their conception of a “charitable” institution. According to Rosemary Stevens, 71 percent of the income for religious hospitals came from patient fees in 1904. Nationwide, government support through tax subsidies dropped to 7 percent of religious hospital income, further increasing a hospital’s reliance on private patients. These trends put financial pressure on institutions to reduce the number of charity cases they accepted.312 Nevertheless, historian Barbara Mann Wall explains that Catholic hospitals maintained their stance as charitable institutions because unlike proprietary hospitals, the sisters “took no share of hospital income to enhance owners’ personal wealth.”313 As not-for-profit institutions, Catholic hospitals emphasized their service to the community even as economic circumstances

While the loss of county funding proved difficult, the extensive national organizational experience of the Daughters of Charity in hospital care provided the necessary tools to meet the challenges of shedding the institution’s social welfare roots and adjusting to a private medical marketplace. By 1875, the Daughters operated a dozen hospitals in the United States, and their national leadership would be very cognizant of the changes in hospital construction, the increased importance of hospitals to physicians, and the value of private patients to a hospital’s bottom line.304 In 1876, the Daughters dedicated a new four-story hospital in Buffalo, New York, that could accommodate nearly 500 patients. Jean Richardson notes that the building was “thoroughly modern by 1870s standards,” including wards with connecting corridors to maximize ventilation, thereby reducing the possibility that “miasma” or “fetid air” could spread disease.305 Although their facility did not need to be quite so large, the Los Angeles sisters had an example to follow when restructuring their institution.

In the 1880s and 1890s, the competitive pressures of the private medical marketplace pushed the Daughters of Charity to reinvent their institution as a modern charity hospital, a scientific institution that incorporated a religious mission. To do so, the Los Angeles sisters adopted many of the strategies used by the Daughters in their other hospitals. First, they constructed a state-of-the-art facility to attract private patients, and they used the fees this generated to subsidize the costs of caring for indigent patients. By building a large facility that included an operating room, the Daughters declared their acceptance of new medical techniques and countered their “un-modern” image. When completed, the sisters operated the second largest medical institution in the city.306 Secondly, the sisters implemented an organizational culture that preserved

311 Starr, The Social Transformation of American Medicine, 173.
312 Stevens, In Sickness and In Wealth, 24.
313 Wall, Unlikely Entrepreneurs, 75.
the best traditions and practices of their religious community, while adapting to new conditions and circumstances. As part of these efforts, the Daughters opened their hospital to “any reputable physician” who wished to treat private patients in the institution.307 Sisters’ Hospital (renamed St. Vincent’s Hospital in 1918) did not follow the national trend of affiliating with a medical school—primarily because Los Angeles only had one medical school, associated with the University of Southern California and staffed by faculty members who supported County Hospital. They offered an alternative for the growing number of surgeons who needed hospital access. Finally, the Los Angeles sisters took advantage of opportunities to engage with the local development of the petroleum and railroad industries, redirecting (in part) the American West’s industrial engine to fulfill their community’s mission to the sick poor. Although the transition was not easy, nor was success guaranteed, the Daughters of Charity managed to adapt to changing circumstances and maintain the vitality of Sisters’ Hospital.

MODERNIZING AMERICAN HOSPITALS, 1860-1930

Scholars such as Charles Rosenberg, Paul Starr, and Rosemary Stevens have analyzed the transition of hospitals from charity institutions to medically-oriented businesses in the late nineteenth and early twentieth centuries. Although the U.S. Census Bureau defined hospitals as “benevolent institutions” in 1904, Stevens argues that religious and other private charity hospitals became increasingly hybridized businesses by the early twentieth century. As community services for the “public good,” hospitals drew on individual charitable giving for buildings and equipment, but they increasingly relied on patient fees to conduct their day-to-day operations. 

Scientific charity advocates promoted self-reliance by avoiding free handouts, and thereby they bolstered a pay system that reinforced social stratification. In the late nineteenth century, elite charity hospitals tended to serve the very wealthy and very poor, and most introduced a graded system of services in which fees were often directly linked to the quality of care. Stevens demonstrates that American hospitals combined charitable impulses, business incentives, and government subsidies throughout the nineteenth century, but that the growing dominance of the pay system steadily tipped the balance towards the “hospital-as-business” model.308

Starr and Rosenberg also agree that business interests began to dominate hospital affairs in the early twentieth century, but Starr asserts that physicians’ professional aspirations drove these changes. He indicates that industrialization, urbanization, and the growth of scientific medicine “reconstituted” the American hospital system steadily tipped the balance towards the “hospital-as-business” model.309

Hospitals provided space and resources to develop new medical techniques and training for medical students. Many physicians viewed them as “doctors’

307 Los Angeles City and County Directory, 1886-1887 (Los Angeles: Times-Mirror Company, 1886), 64.


309 Starr, The Social Transformation of American Medicine, 147.
forced administrators to reduce the number of free beds. Importantly, Wall argues that Catholic sisters created institutions which integrated medical and spiritual values. They maintained a spiritual environment for both pay and charity patients, and this spiritual egalitarianism became nearly as important as continuing the sisters’ mission to the poor. Business and spiritual objectives intertwined. As Wall asserts, financial stability allowed the sisters to reach out to more patients and their families: “The end purpose of their entrepreneurship then, was not to expand profits and market share but rather to advance Catholic spirituality.”

In Los Angeles, the Daughters of Charity crafted a place within the emerging medical marketplace that capitalized on the compassionate devotion of the sisters without limiting their patient base to a single religious group. Religious demarcations did strengthen as the number of Protestants increased in the city during the late 1880s, but with the exception of a brief outburst during the 1894 mayoral election, blatant anti-Catholicism did not become prevalent in Los Angeles until the 1920s. The Daughters did not face the same type of religious competition that spurred the growth of Catholic hospitals in other cities. When they opened their new facility, the sisters extended their philosophical approach of serving impoverished individuals regardless of race or creed, and they reinforced this message in their advertising. In the 1886 city directory, the Daughters asserted, “Patients, irrespective of creed or nationality, are received,” and the compiler of the directory went even further, arguing that

there was “no difference in the treatment and no difference in the charges to the Jew or Gentile, Catholic or Protestant.” The sisters operated a religious hospital, but they did not wish to limit its use to members of the Catholic faith.

Table 5.1 Improvements to Sisters’ Hospital, 1884-1927

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
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<tbody>
<tr>
<td>1884</td>
<td>The Daughters of Charity began construction of the hospital on Sunset Boulevard and Beaudry Avenue. The one hundred-bed facility included “pavilion”-style wards and an operating room.</td>
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<tr>
<td>1902</td>
<td>The Daughters of Charity built the annex, essentially another six-story hotel-style hospital adjacent to the 1884 building. It included an additional operating room, an x-ray machine, steam heat, electric lights, and laboratory space.</td>
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<tr>
<td>1927</td>
<td>The Daughters of Charity opened a new hospital on Alvarado Street and Oceanview Avenue. In addition to its surgical facilities, the hospital featured private and semiprivate rooms, a central kitchen, hydrotherapy treatment center, radiograph, and bacteriology labs.</td>
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**REINVENTING SISTERS’ HOSPITAL, 1884–1907**

Contemporary ideas concerning hospital construction, and the sisters’ past experience with urban development, shaped their decisions about the location and construction of a new hospital. Hospital reformers promoted wide, open, well-ventilated spaces as essential to good health, and the sisters did not want to deal with the environmental hazards of nearby industry or the headaches caused by meddling neighbors. In 1883, the Daughters of Charity purchased “Beaudry Park” for $10,000, approximately nine acres of improved land with “drives, walks, trees, shrubs, and fountains.” Three years later, the sisters purchased an additional eight acres from Victor Beaudry adjacent to the original site. Located on the northeastern edge of town, “the Park” was surrounded by a 190-acre tract of undeveloped land. At the time, it truly had the feel of a “country setting.”

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314 Ibid., 190.

315 The American Protective Association, a national anti-Catholic organization founded by Henry F. Bowers in 1887, made a brief appearance in Los Angeles during the mayoral election of 1894. The local APA (estimated at seventy-five to one hundred members) openly supported Frank Rader, the Republican candidate, while Democrats supported the Catholic William A. Ryan. The Times called the contest a “bitter religious war,” and threw its support behind former mayor Henry T. Hazard, who ran as an independent. Although Ryan claimed that Rader’s anti-Catholic rhetoric would galvanize Republican candidate, while Democrats supported the Catholic William A. Ryan. The

316 Los Angeles City and County Directory, 1886–1887, 64, 143.

317 On 9 March 1883, the Daughters of Charity entered a contract with Victor Beaudry to purchase 9.22 acres of his property near the Canal and Reservoir lands on the northeastern edge of the city. The sisters provided $500 down and agreed to pay the remaining $9500 within thirty days. As part of the agreement, the sisters agreed to sell Louis Cardano a lot of their land on San Fernando Street. They also agreed to purchase water for the “use of the hospital to be erected on said land” from Beaudry Water Works, for seventy-five cents per one thousand gallons. The sisters paid Beaudry the remain-der of the purchase price on 7 April 1883, and received title to the land (they bought an additional eight acres on 9 April 1886). “Minutes, 7 March 1883,” Corporation Book, 1869–1909, SVMCHC, 144 WOMEN, RELIGIOUS MISSION, AND HOSPITAL CARE IN LOS ANGELES 145
The Daughters held a ceremony to lay the hospital’s cornerstone on 14 September 1884 and completed construction by July 1885. The three-story hospital accommodated approximately 100 patients in its long rectangular wards. It had a kitchen, dining room, living quarters for the sisters, and most importantly from a doctor’s perspective, an operating room on the third floor.318 Specialized operating rooms were not yet considered standard in hospital spaces, and even the famed Johns Hopkins Hospital in Baltimore opened without one in 1885.319 In some ways, the Daughters of Charity worked on the leading edge of the industry, but they also included a hen house, stable, and cow pasture in their designs. Ironically, it appears the sisters established the same type of institution as the County Hospital and Farm. However, Sisters’ Hospital did not carry the same ideological baggage as the county’s facility on Mission Road. Gathering eggs and milking cows saved some money, but charity patients were not subject to unrealistic expectations that they would work for their keep, nor would they have to deal with the indignities of being labeled as “unworthy poor.” The 1884 Sunset Hospital was not a poorhouse; it represented a transition between a traditional “home” for convalescence and a modern scientific facility.

To pay for the land, the sisters decided to sell the infirmary grounds on San Fernando street, and to an extent, they were caught up in the land rush that characterized the early eighties. The sisters first put the building and land up for sale in October 1881, but they did not entertain any potential offers until March 1883, when an unnamed buyer offered them $48,000. Instead of accepting the proposal to purchase the land outright, the hospital board chose to subdivide their property into lots in what would then be called the “New Depot Tract.” Each lot would be sold separately.320 In the midst of a real estate boom, it may have looked more profitable to subdivide the land and sell it themselves, and the lots sold well in 1883 and early 1884. The sisters earned $31,960 (although because they did not always require full payment up front, this may have ultimately affected their cash flow when trying to manage their own construction costs). However, real estate sales slowed as outlying areas of the city became more popular. According to the corporate minute book, the sisters made one sale in 1887, another in 1895, and did not sell their last lot in the New Depot Tract until 1916. All told, the proceeds from the land amounted to $40,885.321 The sisters would have been better off taking the initial offer of $48,000. Even so, subdividing the land demonstrates that the Daughters of Charity were willing to take financial risks and adapt to current marketing strategies in order to pursue their ultimate aims. Nor were the sisters averse to borrowing funds to complete the project. In 1885 alone, the Daughters borrowed $35,000 to pay for construction costs and interior furnishings. At the end of 1886, the treasurer reported that the corporation’s total indebtedness was $53,850. Considering receipts for the year were only $16,764.26, the Daughters took a considerable risk, but they certainly believed that constructing a modern facility would be a means to continue their service in the city.322

**FINANCIAL STRATEGIES FOR CHARITY HOSPITALS: BLENDING THE OLD WITH THE NEW**

As part of the modernization process, the Daughters of Charity engaged in financial strategies which balanced the community’s values with the needs of contemporary medical institutions. To begin with, they sought to minimize the outlay of wages and capital to encourage financial stability. At age sixty-five, Sister Juliana Mulvany did all the washing for the facility, as Sister Loyola Law explained, “away under the old system of a hundred years ago.” Sister Loyola, who visited Los Angeles in 1895, sympathized with Sister Juliana: “No steam, no nothing! Just wash tubs and carried water, pitching into the hardest and most laborious work herself.”323 In addition to doing laundry by hand, the Daughters

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321 Minutes, 3 January 1916,” Inserted into Board of Directors Minutes, 1910-1941, SVMHC, Los Angeles; Minutes, 7 March 1883; 12 March 1883; 1 March 1883; 8 May 1883; 17 May 1883; 22 May 1883; 9 October 1883; 13 November 1883; 24 November 1883; 28 November 1883; 31 December 1883; 2 January 1884; 5 May 1884; 21 June 1887; and 4 October 1895,” Corporation Book, 1869-1909, SVMHC, Los Angeles.

322 “Minutes, 16 April 1885; 29 June 1885; 30 October 1885; 1 December 1885; 8 April 1886; 3 January 1887,” Ibid.

323 Sister Loyola Law to Sister Raphael, 24 January 1901, Office of the President/CEO Records,

Census, Sister Juliana Mulvaney was born in January 1836, making her sixty-five at the time the letter was written. U.S. Census, Los Angeles, 1920.

Andrea Gibbs commented, “now we shall have chickens galore.” Utilizing the sisters’ labor meant the hospital did not have to hire and pay wages to many workers, and this allowed them to selectively invest in labor-saving technology.

Whether owning their land, controlling patient admissions and services, or raising chickens, the Daughters of Charity sought to control their work, home, and mission. From their arrival in 1856, the sisters selected land with orange trees and grapevines to provide fruit for the children at the orphanage or to sell for cash. The sisters also had a poultry yard and maintained their own cattle brand.

Also raised chicken and cattle to provide milk, meat, and eggs for the patients at the hospital. Sister Aloysia Schwartzmiller supervised these operations, and she received an incubator in 1901 to assist the hatching of additional eggs. Sister Andrea Gibbs commented, “now we shall have chickens galore.”

In 1861, Sister Scholastica selected the Naud Street property for the hospital because of its water pump, fruit trees, and grapevines. In the last two decades of the century the Daughters continued these traditions. By doing so, the sisters sought ways to reduce cash expenditures and meet their own needs. In part, this represents their frugality, doing more with less. But more importantly, the sisters’ dedication to self-sufficiency illustrates the organizational culture of their religious community, one thoroughly committed to maintaining its autonomy on all levels.

However, the sisters’ traditions and practices conflicted at times with physicians’ desires to craft a “modern” scientific institution. Hand-washing linens and raising chickens did not convey modernity or scientific authority. In addition, physicians consistently advocated improving facilities, particularly in the operating room. By 1895, physicians at the hospital repeatedly complained that the lighting was inadequate for surgery, but the sisters delayed acting on these requests, presumably for economic reasons. When requesting permission to renovate from the Provincial Council in Emmitsburg, Sister Eugenia Fealy explained “this Operating room has been a subject of comment for years.” The sisters touched up the paint and repaired the table, but they needed permission from their superiors before making any substantial (or costly) changes. The operating room was finally renovated in 1895, allowing the hospital to accept more surgical cases. Although Sister Eugenia characterized surgery cases as “troublesome,” they did represent a growing source of income for their hospital and its emerging scientific image.

The Daughters of Charity organized their institution on the general hospital model, providing all types of medical services. When opening the new

Sisters’ Hospital viewed from Sunset Boulevard, c. 1885-1888.

The painting makes evident the pastoral setting of the facility. California Historical Society Collection.

Courtesty USC Libraries Digital and Special Collections, Los Angeles.

Operating room has been a subject of comment for years." The sisters touched up the paint and repaired the table, but they needed permission from their superiors before making any substantial (or costly) changes. The operating room was finally renovated in 1895, allowing the hospital to accept more surgical cases. Although Sister Eugenia characterized surgery cases as “troublesome,” they did represent a growing source of income for their hospital and its emerging scientific image.

The Sisters of Charity: The Daughters of Charity and the Development of Social Welfare in Los Angeles, 1856-1927” (Claremont Graduate University, History, 2010).

1856-1997, SVMCHC HC002, Box 35, Folder 14, SVMCHC, Los Angeles.


The Daughters of Charity opened an orphanage and school in Los Angeles upon their arrival in

1856. Incorporated as the Los Angeles Orphan Asylum in 1869, the school offered academic instruction in English and Spanish, as well as classes in more “lady-like” subjects such as needlework for private students who paid an additional fee. The sisters used tuition dollars from their private students to subsidize the costs of housing, feeding, and educating the orphans who also lived at the school.

Although situated in a prime location in the 1850s, the neighborhood deteriorated in the 1880s. The Daughters built a new facility in Boyle Heights in 1890, where they remained until 1953. At that time, the asylum changed its name to Maryvale, and the Daughters of Charity continue to operate a residential facility for children who are not able to handle foster care. This modern-day orphanage is located in Rosemead, California, about ten miles east of Los Angeles. For more on the sisters’ orphanage, see chapter six of my dissertation, Kristine Ashton Gunnell, “Without Regard to Race or Creed: The Daughters of Charity and the Development of Social Welfare in Los Angeles, 1856-1927” (Claremont Graduate University, History, 2010).


facility, the sisters briefly tried to brand the institution as a sanitarium, changing the name to “St. Vincent’s Sanitarium” in its 1886 advertising. However, the strategy was short-lived. The sisters dropped the name by 1888 and returned to the institution’s official corporate title, “The Los Angeles Infirmary.”

The corporate name was more reflective of the hospital’s actual business. Analysis of admissions records reveals that consumptives did not represent a majority of its patients—14 percent between 1879 and 1886, and only 6 percent between 1889 and 1900 (no records survive for 1887 and 1888). Broken bones, bruises, burns, and other traumatic injuries comprised an important part of the sisters’ business, 12 percent between 1879 and 1886 and 14 percent between 1889 and 1900.330

As a general hospital, the sisters primarily accepted infection and trauma cases, including relatively minor problems such as abrasions, abscesses, and “sore feet.”

In the mid-nineteenth century, hospitals tended to act as warehouses for the sick, caring for those needing long-term care. However, by the 1880s, physicians started to promote hospitals as places to treat acute, but curable, conditions, particularly those requiring surgery. Hospital stays became shorter, and fewer patients remained in residence throughout the entire course of their convalescence.331 In Los Angeles, Sisters’ Hospital accommodated these trends. The sisters offered surgical facilities for acute care when needed, but they did not entirely abandon patients with chronic conditions such as consumption or rheumatism. As in other respects of their business, the Daughters of Charity blended the old with the new.

RAILROAD CONTRACTS: A NEW FINANCIAL STRATEGY TO MAINTAIN THE MISSION

Modernizing the hospital required the Daughters of Charity to develop new financial strategies in order to keep the institution afloat. Growing food and hand-washing the laundry reduced some expenditures, but these measures alone would not sustain the institution. While the Daughters did not make any formal connections with a medical school, they did have surgical facilities to encourage doctors to bring in more private patients, and as a general hospital, the sisters nursed patients with all kinds of maladies. But, working with railroad insurance programs proved to be the most significant development at Sisters’ Hospital in the 1890s and early 1900s. Other religious communities, such as the Sisters of the Holy Cross and the Sisters of Charity of the Incarnate Word, worked with railroads to treat their employees in several places throughout the west. As Edna Marie Leroux, R.S.M., explains, railroads often owned these hospitals and the sisters managed them, receiving a salary and sometimes room and board for their services.332 Thoroughly committed to maintaining their autonomy, the Daughters did not enter into any managerial arrangements, but they did see the advantage of treating sick and injured railroad workers. Many of these workers were Catholic immigrants, and most were poor. Nevertheless, they all paid for company insurance, and railroads reimbursed contract hospitals for an employee’s treatment.

not record a diagnosis, 147 (33 percent) for 1879–1886, and 220 (38 percent) for 1889–1900. “Hospital Admissions Book, December 1872–1896,” “Hospital Admissions Book, 1896–1907,” SVMCHC, Los Angeles. It is unknown how many consumptives were charity patients because the records did not clearly identify charity patients during this time period.

The Daughters of Charity could, therefore, continue to provide healthcare for indigent patients, but also have a steady source of income for the hospital.

Railroads pioneered payroll-deducted corporate health plans in the United States, setting a precedent that dramatically shaped healthcare services in the twentieth century. The Central Pacific hired local physicians at points along the line to care for injured workers, it set up first aid stations at major operations centers, and it opened a company-run hospital in Sacramento in 1867. As the system grew, however, and as not all sick or injured employees worked within a readily accessible distance from Sacramento, the company developed mechanisms to treat patients where they were. By 1889, the company, then named the Southern Pacific, contracted with existing hospitals in San Francisco, Oakland, Los Angeles, Tucson, and Portland to treat its employees. It also contracted with local pharmacies to provide the necessary medicines.334

Excepting Chinese workers, all full-time employees from day laborers to company executives contributed fifty cents per month towards their health coverage. Benefits included “hospital care, medical and surgical treatment, medicines and surgical dressings [and] artificial limbs and appliances.”334 Company physicians treated patients, and sent those with serious conditions to local hospitals for immediate care. If further medical attention was necessary, the company furnished free transportation to Sacramento (or San Francisco after 1899) for the patient and an attendant, reimbursed the attendant for all expenses, and paid him a “reasonable fee” for caring for the patient en route.335

The Southern Pacific recognized that maintaining a healthy workforce was good business. In 1916, company auditor T.O. Edwards commented that the railroad benefited from insurance programs “through improved service” from its employees, although he admitted the exact monetary benefit to the company was difficult to calculate. Edwards noted, “You can’t measure it in dollars, it is a satisfaction to the officials of the Southern Pacific Company to know that their employees are provided.”336 Despite these altruistic intentions, the company also remained acutely aware of their need to control costs—prefiguring tensions that plagued worker’s compensation programs throughout the twentieth century. Then, as now, employers worried that workers would abuse their hospital benefits, and therein lay the heart of the conflict between workers and management over comprehensive health care. The company limited the length of hospital stays and excluded pre-existing conditions, particularly those that their officials defined as resulting from bad personal habits.337 Officials also feared that workers would attempt to extend their hospital stays either to avoid going back to work or to save money on their lodgings. Because of this, the hospital department urged that patients be discharged as quickly as possible.

The Los Angeles County Railroad engine Ivanhoe, stopped at Sisters’ Hospital on Sunset Boulevard, c. 1887. California Historical Society Collection. Courtesy USC Libraries Digital and Special Collections, Los Angeles

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334 Although these regulations were printed in 1915, the basic structure of the program changed little from its inception in the 1870s, particularly the continuance of a prohibition against the inclusion of Chinese workers. Leo Stanley quotes the 1889 hospital rules, and they were remarkably similar to those printed in 1915. Southern Pacific Company, “Southern Pacific Company Pacific System Regulations of Hospital Department, Effective 1 January 1915,” 4, 7–8, F3725:2724 Administrative—Railroad Hospital Reports—Southern Pacific Railroad Company, Railroad Hospital Reports, Public Utilities Commission Records, 1917–1934, California State Archives, Sacramento; Stanley, “Western Association of Railway and Industrial Surgeons,” 924.


337 The guidelines excluded treatment for “venereal diseases, intemperance, vicious habits, or injuries received in a fight or brawl, or unlawful acts.” Southern Pacific Company, “Regulations of Hospital Department,” 9.
The Southern Pacific’s regulations reflected the same tensions that riddled county welfare provision for the poor. Automatically suspect as lazy, immoral, intemperate, or potentially dangerous, these laborers struggled for human respect and adequate care within a paternalistic system that historians would later identify as welfare capitalism.339

Conceptions of poverty and charity remain a key to understanding the dynamics of company-provided health care in the late nineteenth and early twentieth centuries. Was health coverage a right or a charitable act by the employer? Workers did pay minimal fees to participate in the program, but from the company’s perspective, healthcare remained a paternalistic act of charity, a necessity for the “suffering humanity” who just happened to be in their employ. As such, the company served a similar function—and felt similar financial pressures—as county boards of supervisors charged with caring for the indigent sick. The race and class biases that circumscribed middle-class perceptions of the poor would also influence the company’s management, who believed the railroad to be the very symbol of American progress. Mexican, Chinese, and Japanese workers were tolerated because of their economic expediency, but the company put considerable effort into controlling their behavior, at least in part, by regulating the availability of health services. The prevalence of race and class biases, and the inherent tensions between labor and capital, meant that sick workers needed advocates, people to mediate for them at a very vulnerable time. As nurses, the Daughters of Charity were positioned to meet this need.

From the perspective of the Daughters, contracting with railroad health programs made good business sense. As the numbers of private sanitariums in Southern California grew in the 1880s, the competition for consumptives increased. The numbers of consumptives treated at Sisters’ Hospital declined by 1890, and the Daughters of Charity had to look for a new source of income to attract paying patients. The railroad contracts provided a viable way to expand the sisters’ services and still continue to treat the sick poor. The Daughters made their connection to the railroad through Dr. Francis K. Ainsworth, the physician who informally acted as chief of the medical staff at Sisters’ Hospital. Ainsworth began working as Southern Pacific’s Division Surgeon in Los Angeles in 1888, a position he held until taking over as Chief Surgeon at Southern Pacific’s General Hospital in San Francisco in 1903.340 The sisters worked with Southern Pacific during roughly the same period, until the Crocker Street Hospital opened in 1908.341

Demographic data included in the hospital admissions books from 1889 to 1907 demonstrates who received service, the types of care covered by railroad programs, and the extent that health care services were needed. Between 1889 and 1900, 22 percent of all patients treated at Sisters’ Hospital worked for the Southern Pacific Railroad. The percentage dropped to 20 percent between 1901 and 1907, but this slight dip was more than made up by the treatment of employees from the Santa Fe and Pacific Electric Railroads. Between 1901 and 1907, nearly half of all patients treated at Sisters’ Hospital worked for a railroad, including many Japanese and Mexican workers. The Daughters used their initial connection with Ainsworth to gain experience treating railroad workers and learned the ins and outs of the contract system. The sisters then parlayed this experience into a marketing strategy used to attract business from other companies.

In addition, the Daughters of Charity developed another revenue stream nursing sick or injured sailors in the early twentieth century. Between 1901 and 1906, seamen accounted for 7.6 percent of the hospital’s patients, 167 sailors in the 1905 fiscal year alone.342 Like railroad work, sailing could be hazardous. William Nielson received substantial bruises and internal injuries while unloading cargo in San Pedro in 1905, and other sailors were admitted with broken bones, typhoid, malaria, or rheumatism.343 By treating commercial sailors, the Los Angeles sisters

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338 Ibid., 5.
339 Beginning in the 1890s, businessmen such as Henry Ford, S.C. Johnson, and Henry S. Dennison developed corporate welfare policies that sought to shield workers from the most egregious effects of unrestrained capitalism. Although benefits varied widely between companies, welfare programs could include profit-sharing, health insurance, pension programs, paid vacation, company housing, social clubs, cafeterias, childcare, and athletic facilities. Welfare capitalists believed that the company should be the source of worker benefits and protections, rather than unions or the government. Moral obligation motivated some corporate magnates, but most saw employee benefits as a means to undermine unions and delay the implementation of government-sponsored social insurance programs like Social Security. See Sanford M. Jacoby, Modern Manors: Welfare Capitalism Since the New Deal (Princeton, N.J.: Princeton University Press, 1997), 3-7, 11-26.
340 Short asserts that Ainsworth was instrumental in rebuilding the San Francisco and Sacramento hospitals after the 1906 San Francisco earthquake and fire. The San Francisco hospital was located on Fell and Baker streets, a facility that eventually had a 300-bed capacity. Ainsworth served as chief surgeon until 1926. Short, Railroad Doctors, Hospitals, and Associations, 5-6.
341 The first mention of the Crocker Street Hospital treating either victims of railway accidents or railway employees occurs in the fall 1908. These accidents involved either Southern Pacific or its subsidiary Pacific Electric. In 1905, the Santa Fe Railroad also decided to open its own hospital, located in Boyle Heights. Presumably, this meant a reduction in, if not the elimination of, its employees being treated at Sisters’ Hospital. To date, I have not been able to find a stated reason for the company’s decision to open its own hospital. See “Fine Hospital Open in a Week: Santa Fe’s Best Haven Nearly Ready for Use,” Los Angeles Times, 26 October 1905; “Baby Crushed Under Wheels,” Los Angeles Times, 21 November 1908; “Jammed in Tunnel,” Los Angeles Times, 30 March 1909.
342 “Marine Hospital for San Pedro,” Los Angeles Times, 28 March 1906; “Hospital Admissions Book, 1896-1907.”
borrowed a financial strategy used in other hospitals owned by the Daughters. In the 1891-1892 fiscal year, sailors’ care represented 15.6 percent of the income received by the sisters’ hospital in Buffalo, New York. The U.S. Government paid sailors’ medical expenses, although it was funded through a tax on seamen serving on American vessels. In 1798, Congress passed an “Act for the Relief of Sick and Disabled Seamen,” the intent of which was to defray sailors’ health costs and fund a series of government-run hospitals under the auspices of the Marine Hospital Service (MHS). By 1901, MHS operated twenty-one hospitals in the United States (including one in San Francisco); it also maintained a fund for sailors needing hospital care. When seamen required treatment in a city, like Los Angeles, where the agency did not operate a hospital, MHS authorized payment for sailors’ care at another facility. Similar to railroad workers, sick seamen were often far from home, living without their families, and possessed limited resources beyond their government-sponsored health benefits. These insurance programs allowed the Daughters of Charity to secure some financial stability, while remaining focused on providing services to the working (and sick) poor.

The railroad health program was not merely worker’s compensation for injuries as we think of it today, but a broad-based program which encompassed many aspects of an employee’s life and health. Most injuries were probably sustained on the job, and rheumatism likely resulted from years of hard physical labor and exposure to the elements. But, the company also treated conditions that may have resulted from exposure to contagion among workers in their living quarters, or conditions that simply cropped up through everyday living. Of the Southern Pacific employees treated at the hospital, about one third came in with injuries such as a broken arm, crushed fingers, or sprained ankles. These were emergency situations which required immediate treatment, but not necessarily serious conditions that required long term care or a transfer to the company’s hospital. Sisters’ Hospital also treated railroad workers with typhoid, bronchitis, influenza, fevers, and various types of infections, and this represented another third of their cases (table 5.3, Appendix A). Unfortunately, uneven record-keeping practices meant diagnoses often went unrecorded, so it is impossible to know whether the remaining third of railroad patients were admitted for major or minor maladies.

In 1871, MHS was reorganized with a military-like structure, and its duties were soon extended to include the prevention of contagious disease. In 1902, the name was changed to the United States Public Health Service. United States Public Health Service, Annual Report of the Supervising Surgeon General of the Marine Hospital Service of the United States (Government Printing Office, 1901), 11-12; William E. Rooney, “Thomas Jefferson and the New Orleans Marine Hospital,” The Journal of Southern History 22.2 (May 1956), 168, 177-179; Lucy Minnigerode, “The United States Public Health Service,” The American Journal of Nursing 25:6 (June 1925), 454-456. For a more detailed account of the early MHS, see Robert Straus, Medical Care for Seamen; the Origin of Public Medical Service in the United States (New Haven: Yale University Press, 1950). As for the treatment of sailors at Sisters’ Hospital in Los Angeles, the admissions records sampled reveal that most of them were born outside the United States, but they may have qualified for the insurance fund if serving on American ships. Or, ships’ captains may have paid for their care if serving on a foreign vessel. The records also indicate that four “U.S. Seamen,” presumably belonging to the U.S. Navy, were treated at Sisters’ Hospital in 1900. Forty-four sailors were included in my sample of 579 patients between 1901 and 1907. “Hospital Admissions Book, 1896-1907.” In July 1906, the Treasury Department, which oversaw the MHS, announced that Angelus Hospital would provide sick and injured sailors with “quarters, subsistence, nursing, medicines, anesthetizing, surgical dressings, and extra nursing for delirious” patients at the rate of $1.45 per day. Patients who needed additional hospital care and were able to travel would be transferred to the Marine Hospital in San Francisco. “Medical Care of Sailors,” Los Angeles Times, 6 July 1906. I was unable to locate the daily rates for Sisters’ Hospital in the same time period, but MHS may have changed contract hospitals because Angelus negotiated a better rate.

Richardson, A History of the Sisters of Charity Hospital, Buffalo, 173.

The 1798 act assessed a tax of twenty cents per month on any sailor working aboard an American ship. While the government did build marine hospitals in some U.S. seaports, there was an early precedent of contracting space in existing hospitals. Dr. William Barnwell treated sick sailors at the Charity Hospital in New Orleans between 1804 and 1809. This pattern may have been used elsewhere, or the Marine Hospital Service may have just paid the bills at facilities such as the sisters’ hospital in Buffalo.
Because it burned in the 1906 earthquake and fire, comparable numbers are not available for Southern Pacific’s General Hospital in San Francisco. But, in 1883, the Central Pacific Railroad Hospital in Sacramento reported that 10.8 percent of cases treated by company physicians were due to injury. By far the majority of workers needing care were afflicted with malaria (1200 cases), colds (656 cases), or rheumatism (182 cases).\(^2\) Perhaps with the exception of rheumatism, these conditions required short-term stays in the hospital, if a patient was admitted at all.

How did working with the railroads affect the sister’s health care practices? Since approximately 44 percent of their patients were railroad employees, the Daughters of Charity would have to accommodate company health policies. However, there are some important points to consider. Railroads owned some of the hospitals in which sisters from other communities worked, but the Daughters owned their hospital in Los Angeles. The railroad company did not pay the sisters a salary, nor did it exclusively control admissions and treatment. If the sister-nurses thought more care was necessary than the company would pay for, then they had the capability to extend a patient’s stay—on their own dime, of course. They could, perhaps, intercede on behalf of a patient with a doctor or company official to soften what they considered prejudicial attitudes. The sisters provided a conduit of care. When they partnered with the county, the Daughters acted as intermediaries between impoverished individuals and the state. At the turn of the twentieth century, they acted as intermediaries between workers and an emerging corporate bureaucracy.

**RACE AND GENDER AT SISTERS’ HOSPITAL**

Throughout its history, Sisters’ Hospital drew its patient base from the European and U.S.-born population. Between 1872 and 1907, 40 percent of all patients (whose birthplace was recorded) were born in the United States, and 50 percent between 1889 and 1900 (tables 5.6–5.8, Appendix A). Given the Irish-American background of many sisters, it is not surprising that a large number of Irish patients gravitated towards the institution, although the percentages dipped from 26 percent of all patients in the 1870s to 18 percent by 1907. In addition, 62 percent of the hospital’s private (non-railroad) patients were born in the United States, and nearly all of the others came from Northern Europe, between 1889 and 1900, and forty-seven between 1901 and 1907. Between 1889 and 1900, forty patients did not have a diagnosis recorded, and the remaining had various ailments. The number of patients with an unrecorded diagnosis for 1901–1907 was twenty-nine. Although record-keeping had improved somewhat, this still represented 24 percent of Southern Pacific patients admitted to Sisters’ Hospital. “Hospital Admissions Book, 1896-1907.”

348 Of the 579 records sampled between 1900 and 1907, 116 were categorized as private (non-railroad), amounting to 20 percent of the total patient population. Seventy-two of those were born in the United States, while the others came from Austria, Canada, England, France, Germany, Holland, Ireland, Scotland, Sweden, and Wales. Only four people, from Italy and Mexico, would likely be considered marginally white. “Hospital Admissions Book, 1896-1907.”

349 Between the years 1889 and 1900 only 70.7 percent of patients were men, but 88 percent of patients were male between 1872 and 1878, 82.5 percent between 1879 and 1886, and 81 percent between 1901 and 1907. “Hospital Admissions Book, December 1872-1896”; “Hospital Admissions Book, 1896-1907.”

350 Working with the railroads further magnified this diversity. During the 1890s and early 1900s, the percentage of Mexican and Japanese patients increased. Between 1901 and 1907, Mexican-born patients comprised 7 percent of the total patient population and Japanese 5 percent. Most of these were railroad workers. T The percentage of patients of Mexican descent could actually be

higher, since patients were differentiated by place of birth, not ethnicity or race.352

How were people of color treated in the hospital? The railroad’s contract physician treated its company’s workers, but all patients in the wards would have received similar care from sister-nurses. Private patients, 22 percent of the total, would receive more individualized care if they stayed in a private room.353 Admissions records suggest that nearly all of these patients were white. However, widespread economic discrimination against people of color meant that few Mexican or Japanese patients would have been able to afford the fees associated with a private room. In 1886, the advertised rates for these rooms ranged from ten to fifteen dollars per week, while patients housed in the wards paid eight dollars per week.354 The Daughters used these fees to subsidize care for the sick poor, so it would be unlikely that a patient was housed in a private room unless he or she could afford to pay. However, it does not necessarily follow that the Daughters of Charity segregated nonwhite patients at Sisters’ Hospital. Between 1901 and 1907, 50 percent of ward patients were born in either Ireland or the United States, and most would have considered themselves white.355 Coming from similar class backgrounds, white and nonwhite patients may have been housed in the same ward. But this is difficult to confirm, or deny, for that matter. No existing records indicate whether or not Sisters’ Hospital had segregated wards.

Gender also complicates our understanding of the dynamics at Sisters’ Hospital. In sharp contrast to other nineteenth-century institutions operated by women, men comprised the vast majority of patients treated in the institution (table 5.11, Appendix A). Domestic ideology placed high public value on motherhood and women’s responsibilities to protect the home. Even though many American women engaged in a range of economic activities outside their immediate households, writers, ministers, and politicians tended to assign a more “proper” role to them in the private sphere, separate from men’s public activities. However, many middle-class women’s groups extended their public presence and bolstered their moral authority by acting as advocates for other women and children.356 These women transformed nineteenth-century domestic ideology by raising money to assist widows, operating orphanages, and founding lying-in hospitals for socially disgraced, and pregnant, young women.357

Dr. Charlotte Blake Brown used the doctrine of separate spheres to create an autonomous space for women physicians and hospital administrators. In February 1875, Brown and Dr. Martha E. Bucknell opened the Pacific Dispensary Hospital for Women and Children in San Francisco, renamed the Hospital for Children and Training School for Nurses in 1885. Brown and Bucknell organized the hospital in opposition to the male-dominated medical profession. All physicians on staff were women, and women controlled the board, hospital policies, and the day-to-day management of the institution. The hospital also trained medical interns

352 The U.S. Census did not categorize “Mexican” as a separate racial category until 1930, and other institutions mirrored that practice. When the hospital was funded by Los Angeles County, residency remained a major qualification for receiving payment for a patient’s treatment, and therefore, important in the sisters’ record-keeping practices. Although Sisters’ Hospital did not extend county-funded relief after 1878, given its history, place of birth and residency continued to be important markers of patient identity. However, many individuals of Mexican descent were born in the United States, and thus, they are indistinguishable in the existing records. Due to the St. Vincent Medical Center Historical Conservancy’s interpretation of government health privacy requirements (i.e. HIPAA), patient names were not collected, so last names (although a less-than-perfect indicator of ethnicity) are not available to determine a patient’s heritage.

353 The Sanborn Insurance maps provide the best clues to the interior set-up of the hospital. The 1888 map does not indicate that the hospital had private rooms, but the 1906 map, completed after the 1902 addition to the hospital was finished, shows that the second floor of the old hospital had been transformed into private rooms. Private rooms and wards were also included in the new wing. “Sanborn Insurance Company Map, Los Angeles, Vol. 1, Sheet 13a, 1888” (Proquest Databases, accessed 18 November 2008); “Sanborn Insurance Company Map, Los Angeles, Volume 3, Sheet 325, 1906.”

354 Los Angeles City and County Directory, 1886–1887, 64. By 1888, the hospital did not publish its rates in advertisements, but advised interested parties, “For Terms Inquire at Infirmary.” This allowed more flexibility in charging fees according to what the market would bear, and would allow the sisters to make specialized contracts for railroad companies, benevolent associations, etc. Los Angeles City Directory (1888), 11; Los Angeles City Directory (Los Angeles: W.H.L. Corran, 1891), 243. Incidentally, the Daughters of Charity raised their rates when opening the 1884 hospital. In 1879, the sisters advertised rates from six to fourteen dollars per week. Fourteen dollars was probably the private room rate. “Advertisement. Los Angeles Infirmary,” Los Angeles Herald, 21 June 1879.

355 In the sampled records from 1901 to 1907, eighty-two patients were admitted as “ward patients.” Sixteen patients reported their birthplace as Ireland; and thirty-five reported it as the United States. Other patients in this category came from Canada, England, Austria, France, Germany, Italy, Mexico, Japan, and Portugal. Four records left the birthplace blank. “Hospital Admissions Book, 1896-1907.”


357 A lying-in hospital is a facility that provided food, shelter, and nursing care for women in the late stages of pregnancy, as well as care for mothers and infants during and after delivery. Because of the high incidence of puerperal fever and maternal mortality, few women with other options chose to give birth in a hospital during the nineteenth century. Typically, only those women without supportive friends, family, or financial resources would use these facilities. A majority of these women, over ninety percent at some facilities, were unmarried. Morris J. Vogel, The Invention of the Modern Hospital, Boston, 1870–1930 (Chicago: University of Chicago Press, 1980), 12–13.
and nurses after 1885. According to historian Regina Morantz-Sanchez, female physicians established separate institutions both to provide specialized training and professional opportunities for doctors, and also because many women physicians hoped to focus on the specific needs of women patients. Although many women physicians viewed separate institutions with suspicion, they did provide a platform for professional growth. Physicians like Bucknell and Brown extended a maternal cloak over their charges in women’s and children’s hospitals, securing a professional space for medical women in a field where they were only reluctantly included.

San Francisco’s Hospital for Children and Sisters’ Hospital in Los Angeles illustrate two different paths for women within medicine during the last third of the nineteenth century. The leaders of both institutions emphasized the importance of women’s economic autonomy, but Bucknell and Brown opened the Hospital for Children as a means to secure more opportunities for women physicians, mirroring the career-oriented ethos that infused scientific medicine. The Daughters of Charity did not compete with doctors for medical appointments, choosing instead to continue their positions as nurses and hospital administrators—an accepted role for Catholic sisters within the church. Controlling the board, hospital finances, and admissions practices allowed the women at both institutions to negotiate from a position of strength with others who had an interest in hospital affairs.

Despite their similarities, the two hospitals followed different trajectories. Brown and Bucknell limited the scope of their operations to women’s “natural” constituency, other women and children. The Daughters of Charity operated a general hospital that treated primarily men. Why were Catholic sisters not restricted to working with women and children like Brown and Bucknell’s women physicians? As nurses, Catholic sisters did not directly challenge male physicians for an equal place in an increasingly competitive profession. Women physicians, on the other hand, could, theoretically at least, pose a threat, and they were, therefore, pushed into less lucrative positions within the field. However, while sister-nurses did not necessarily challenge physicians’ authority, sister-administrators did, and physicians and administrators had to carefully negotiate a balance in order to successfully maintain an institution. But, Charlotte Blake Brown sought to create a new professional space for women, while Catholic sisters already had established positions as nurses and hospital administrators. Whether by happenstance or historical precedent, Catholic sisters were socially accepted as caretakers for sick and injured men.

Although male sailors and railroad workers dominated patient rolls, the numbers of women seeking treatment at Sisters’ Hospital generally increased throughout the nineteenth century, reaching 29 percent between 1889 and 1900, and 18 percent between 1901 and 1907. Dr. Francis K. Ainsworth delivered the daughter of Mr. and Mrs. John Casey on 31 May 1899, the first obstetrical case at the facility. While hospital births did not become commonplace until the 1920s, surgeons did begin to bring more difficult cases into the operating room in the 1890s. The first caesarian section was performed at Boston’s Lying-in hospital in 1894, and physicians completed over one hundred of these operations by 1907. At Sisters’ Hospital, the numbers of obstetrics cases continued to remain small, less than 2 percent of the patients in my sample between 1901 and 1907. However,


360 Vogel, *The Invention of the Modern Hospital*, Boston, 117.
361 H. Baker, “The History of Our Training School,” in *La Marillac: The Second Annual of the St. Vincent’s Hospital School of Nursing* (Los Angeles, 1926), College of Nursing Collection, Box 3, Folder 28, SVMCHC, Los Angeles. Between 1901 and 1907, nine obstetrics cases were included in a random sample of patient records. Five hundred seventy-nine of the total 8488 records were included in the sample. “Hospital Admissions Book, 1896-1907.”
women apparently sought hospital care for other gynecological issues, including hysterectomies, fibroid tumors, curettage, and other surgical operations. In 1905, Dr. Carl Kurtz performed a noteworthy surgery on a woman suffering from stomach cancer, removing five-sixths of the organ in an attempt to extend the woman’s life.362

The hospital’s industrial contracts largely explain the gender imbalance at the facility, but religious prescriptions may also have affected the recruitment of female patients. As codified in the Normae of 1901, Rome defined nursing in surgical and obstetrics cases as unbecoming for “virgins consecrated to God.”363 However, Barbara Mann Wall suggests that some religious communities circumvented these rules on the grounds of their impracticality. Some superiors told sister-nurses to “guard their eyes” from indecencies, while others quietly encouraged them to observe and supervise surgeries to ensure doctors did not perform abortions or other procedures the Catholic Church opposed.364 Hospitals relied on the labor of sister-nurses, and increasing an institution’s financial security relied on modern surgical procedures. Like other communities throughout the country, the Daughters of Charity negotiated a balance between the economic pressures to modernize and religious prescriptions that could potentially circumscribe their mission.

OIL AS A FINANCIAL STRATEGY

Besides obtaining industrial contracts for the treatment of railroad workers, the Daughters of Charity also creatively adapted to local economic opportunities to secure their hospital’s financial stability. Led by Edward L. Doheny in the early 1890s, prospectors tapped into the oil fields that lay beneath the surface of the city. By the end of 1894, oil derricks lined both sides of State Street, and the number of wells in the city reached 155.365 The sisters’ property on Sunset and Beaudry also sat on the oil field, and the Daughters had to balance opportunities to draw potential income from it with the need to preserve their hospital’s image as a helpful, peaceful place. If oil wells started to dominate the hospital’s landscape, it could drive away private patients—the bread and butter of the sisters’ financial base.

Fearing for the hospital’s reputation, the Daughters of Charity resisted any attempts to develop the petroleum resources in the area. In 1895, Sister Eugenia Fealy reported that F.H. Flint “bought the hill beside the Hospital for the purpose of boring for oil.”366 Along with their neighbors, Sister Eugenia filed a petition against Flint with the Fire Commission, the city agency responsible for issuing oil permits. Although she did not attend the meeting herself, other neighborhood residents argued that the smoke, soot, and fumes constituted a public nuisance and that oil production should be regulated.367 Sister Eugenia believed “these oil wells would certainly injure our Hospital very much,” but neither the Fire Commission nor the City Council was willing to stop the drilling.368 Oil wells were politically popular; they brought income into the city and reduced the cost of fuel. The city council sided with the oilmen, although they did limit night-time drilling activities and cautioned prospectors to manage their operations “as cleanly as possible.”369 The Daughters’ petitions largely fell on deaf ears, their protests interpreted as obstacles to economic progress.

When political resistance failed, the sisters resorted to other methods. Flint’s first well mysteriously became plugged up, but undeterred, his workers started to drill on the other side of the hill—the side which directly faced the hospital. According to Sister Eugenia, the workers boasted “if oil was found here, the Flint hill... would be decorated with one hundred derricks.” She lamented, “Imagine, dear Mother, how we would look beside them.” But this well too proved unproductive; something blocked the bore hole and the machinery kept “dogging up and breaking.” Flint gave up the project, and a worker commented

363 According to Mary Ewens, O.P., two papal bulls were issued in the early twentieth century that particularly affected women religious. Conditae a Christo (1900) offered formal recognition to congregations whose members took simple vows. Normae (1901) provided a guide for congregations that sought to receive papal approval for their constitutions, a measure designed to reduce conflicts arising from questions about a bishop’s jurisdiction over religious communities. However the bulls also noted activities which women religious should avoid, including infant and maternility care, managing clerical seminaries, and teaching in co-educational schools. Ewens notes, “Since operating and delivery rooms were thought to be especially dangerous, they were to be staffed by physicians and trained nurses rather than sisters,” Ewens, Rule of the Nun, 255-256. Apparently, the hierarchy worried that sisters would have difficulty retaining chaste thoughts and actions in the face of such close interactions with patients’ bodies, or in the case of childbirth, the natural result of a sexual union between a man and woman. For further discussion on the problems caused by the conflict between medical science and the sisters’ constitutions, see Ibid., 265-274. Angelyn Dries, O.S.F., “The Americanization of Religious Life: Women Religious, 1872-1922,” U.S. Catholic Historian 10:1/2 (1992, 1991), 23.
364 Wall, Unlikely Entrepreneurs, 180-185.
366 Fealy to Flynn, 20 October 1895.
367 “At the City Hall: Fire Commission Awaiting Council’s Action on Oil Well Permits,” Los Angeles Times, 16 May 1895; “At the City Hall: Fire Commissioners. The Board Besieged by Applications for Oil Permits,” Los Angeles Times, 30 May 1895.
368 “Afternoon Session: Long-Delayed Oil Ordinance Was Adopted Yesterday,” Los Angeles Times, 17 September 1895; Fealy to Lennon, 17 June 1895; “Oil Ordinance: A Restraining Measure That May Be Proposed,” Los Angeles Times, 7 June 1895.
369 Fealy to Flynn, 20 October 1895; “Afternoon Session: Long-Delayed Oil Ordinance Was Adopted Yesterday.”
to one of the sisters that “it really looked as if we had ‘put up a job on Flint.’”

Although pleased, the sisters merely attributed the results as an answer to prayer.

Eventually, the sisters found a way to take advantage of the oil deposits. Sister Eugenia had originally proposed that they start leasing their land in 1895, when the success of Flint’s project seemed certain. She entertained several offers to drill on the chicken ranch and cow pasture behind the hospital in 1898, but did not enter into any contracts until 1900. The Provincial Council in Emmitsburg then authorized Sister Eugenia to make the lease, but instructed her “to require the royalty in cash and not in oil.” In June 1900, the Daughters of Charity leased a small strip of land on the edge of the hospital grounds to the Oceanic Oil Company. The sisters negotiated a ten-year lease which authorized the company to drill wells and develop the land’s petroleum resources. In exchange for the right to drill on their property, the sisters received “1/6 part of the net value of all oil, gas or other substances obtained from such premises.”

Although instructed to take the royalties in cash, the contract allowed the sisters to receive their proceeds either in cash or oil. In addition, Oceanic Oil agreed to provide all natural gas the sisters required “for any purposes in the Hospital building,” as long as the sisters paid for the construction of the gas lines. In this way, the Daughters were able to supply their natural gas needs without any direct cost, and could redirect those funds into caring for poor patients.

Importantly, the sisters preserved the aesthetic value of the hospital grounds. Before Sister Eugenia’s superiors authorized any lease, she had to assure them that the wells would not detract from the hospital’s image. In her letter requesting permission to proceed in 1898, she wrote, “All agree that these well[s] can not injure our Hospital, since they will be back of the building, and well concealed by the trees.” When the sisters signed with Oceanic Oil, they wrote into the contract that the company could not sink any wells within fifteen feet of the entrance to the hospital grounds and required all derricks be removed as soon as it was practical. At the termination of the lease, Oceanic Oil was required to restore the land to its current state as of 1900, removing all buildings and pipelines.

The Daughters remained conscious that the hospital was “home” for the sisters, nurses, and patients; they did not want the grounds spoiled by industrial waste.

### The “Annex”: Modern Design and a Spiritual Setting

When the Daughters of Charity entered into the contract to allow oil wells on their property, they were in the midst of adding a new wing onto the hospital. Nicknamed “the annex,” the building was effectively a new hospital added onto the old. Construction costs for the six-story building totaled $150,000, but the new facility more than doubled the hospital’s capacity and increased its bedspace from 100 to 250. The facility also contained as many as fifty private rooms, many of which were furnished by benevolent societies such as the Elks and the Knights of Columbus. The annex represents the Daughters’ ongoing efforts to adapt to the private medical marketplace, securing luxurious accommodations for private patients and acquiring the latest technological equipment.

The sisters’ decision to expand reflected growing competition among hospitals in the city. In 1898, Dr. Walter Lindley gathered a group of physician-investors (including at least two doctors from Sisters’ Hospital) to open a hospital and nursing school. By 1900, California Hospital had eighty-five beds, reputable physicians, and the labor of unpaid students. It posed an immediate threat in the competition to attract private patients. Although much smaller, the Hospital of the Good Samaritan built a new thirty-bed facility in 1896, and added an additional wing in 1899. As the only other major religious hospital in the city, this Protestant-led hospital also sought to provide a spiritual environment for its patients. Like Sisters’ Hospital, Good Samaritan opened its doors to patients regardless of religious affiliation, and it allowed patients to be attended by their preferred ministers, including Catholic priests. If Catholic patients could receive the sacraments at either hospital, then it was in the best interest of the Daughters to invest in a state-of-the-art facility, so they could better attract both Catholic and Protestant patients. Feeling pressure from both religious and secular hospitals, they responded by opening their own nursing school and embarked on a massive construction project to upgrade their facilities.

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370 Fealy to Flynn, 20 October 1895.
371 Fealy to Lennon, 17 June 1895; Eugenia Fealy, D.C., to Mariana Flynn, D.C., 14 April 1898, Office of the President/CEO Records, 1856-1997, SVMCHC, Los Angeles.
372 “Handwritten Note,” c. 1900 or 1898, Office of the President/CEO Records, 1856-1997, SVMCHC HC002, Box 35, Folder 15, SVMCHC, Los Angeles. This note could have been written when Fealy first submitted proposals for approval in 1898, but it is probably more likely that it reflects the permission given for the 1900 contract, wherein Fealy was offered a 1/6 royalty.
373 “Resolutions of the Board of the Los Angeles Infirmary Re: Oceanic Oil Company,” 1900, Corporation Book, 1869-1909, SVMCHC, Los Angeles. Note: by waiting to lease the oil rights, the sisters received higher royalties. The first offer in 1895 was for a 1/8 royalty. Fealy to Lennon, 17 June 1895.
374 Ibid.
375 Fealy to Flynn, 14 April 1898.
376 “Resolutions of the Board of the Los Angeles Infirmary Re: Oceanic Oil Company.”
They sought to retain a leadership position within the hospital industry in Los Angeles. Yet, the sisters’ expansion was not merely reactionary, and competition between the institutions went both ways. Two years after the sisters opened the annex, Good Samaritan closed for ten months of renovations, constructing a 104-bed hospital in 1904 to stay on par with the sisters’ advanced facilities.377

377 Clark, A History of Good Samaritan Hospital, 20, 28; Harnagel, “The Life and Times of Walter

While Sisters’ Hospital competed with California and Good Samaritan for private patients, Los Angeles County Hospital acted as a rival in technological advancement. Because of its association with the University of Southern California’s medical school, County Hospital was often the first to get new equipment. In 1900, County Hospital renovated its operating room, which the Los Angeles Times reported to be “the best lighted and best appointed in the city.” The renovations also included the construction of an x-ray laboratory, and the Times reporter claimed it was “the most complete ever brought to Los Angeles.”378

In 1902, Estelle Doheny donated an x-ray machine to Sisters’ Hospital, although Sister Helen McMahon remembers that Dr. A.J. Murrietta burned his hands while trying to figure out how to use it.379 By obtaining an x-ray machine, the Daughters of Charity could provide the best diagnostic equipment for paying and non-paying patients alike, thereby cementing the hospital’s place atop the medical field. In Los Angeles, few hospitals had x-ray machines or used them extensively until the 1920s. In fact, Good Samaritan did not have an x-ray machine until 1918.380

Dedicated as the “New Los Angeles Infirmary” on 11 December 1902, the annex emphasized elegance, modernity, and order. Palm trees lined the walkways, and the stone driveway that led to the side entrance, emphasizing the beauty and magnificence of the hospital’s recuperative environment. To remind visitors of its religious nature, the sisters placed a statue of Saint Vincent de Paul prominently in the spacious lobby, which was elegantly decorated with tile floors, dark wooden staircases, a grandfather clock, and chandelier. The hospital also included modern conveniences such as steam heat and electric lights, as well as an additional operating room and laboratory space.381 The 1902 hospital blended design elements borrowed

378 “Alleviating Misery: Many Improvements Made in the County Hospital,” Los Angeles Times, 14 April 1900.


380 Clark, A History of Good Samaritan Hospital, 43.

381 The First Annual of the St Vincent’s School for Nurses, Los Angeles, 1925, 26-27, College of Nursing Collection, Box 3, Folder 27, SVMCHC, Los Angeles; “Sanborn Insurance Company Map, Los Angeles, Volume 3, Sheet 325, 1906”; “Invitation to the Los Angeles Infirmary Dedication,” 1902, Office of the President/CEO Records, 1856-1997, SVMCHC HC002, Box 35, Folder 13, SVMCHC, Los Angeles. For more on the religious significance of hospital architecture and design, see Wall, American Catholic Hospitals, 55-60; Annmarie Adams, Medicine by Design: The Architect and the Modern Hospital, 1893-1943 (Minneapolis: University of Minnesota Press, 2008).
Daughters engaged in a significant amount of non-institutional charity work. As time and resources permitted, the sisters visited the impoverished individuals in their homes and offered aid to those who sought them out at the hospital.

By conducting home visits, the Los Angeles sisters continued the traditions established by Vincent de Paul and Louise de Marillac in the seventeenth century. De Paul taught that “visiting persons who are poor is, in itself, an action very pleasing to God,” and he instructed sisters to visit the homes of the sick, thereby offering both spiritual and material sustenance to those in need.84 In Los Angeles, the annual reports assert that hospital sisters “visited and relieved” an average of one or two families per week between 1915 and 1930.85 These may have been follow-up visits to patients discharged from the hospital, assisting mothers with sick children, or visiting the elderly in the neighborhood who needed assistance but were not sick enough to require hospital care. In seventeenth-century France, illness pushed poor families to the edge of their resources, depriving breadwinners or caregivers of the time and energy to work in the shop, the house, or the field. Although urban residents exchanged the blacksmith forge for the factory floor by the twentieth century, unexpected illness could have the same devastating effect on working-class families. From the perspective of the Daughters of Charity, the need for their services was the same.

Home visits should also be considered in the context of other charitable activities within the city. Protestant-led charity organization societies, often known as Associated Charities, promoted “friendly visitor” programs throughout the United States. Either as paid agents or volunteers, these men and women visited families and offered instruction, advice, and occasionally arranged for relief. Intended to inculcate morality, thrift, and sobriety, the programs often functioned as de facto forms of Protestant proselytizing. As the Catholic hierarchy became more sensitive to the threat of “leakage” from Protestants’ charitable activities, clergy heightened their emphasis on visiting as part of Catholics’ duty to care for their poor coreligionists. Deidre Moloney asserts that the Society of St. Vincent de Paul, a male-dominated lay organization, largely served this function in the late nineteenth and early twentieth centuries.86 The Daughters of Charity were involved in similar efforts. But unlike some clergy, the sisters did not define their service as a response to religious competition. Instead, home visits represented the


84 “Council of July 5, 1646,” CCD, 13b:251-262.


continuation of a long-standing commitment to care for those living in poverty.

While the Daughters of Charity continued their tradition of home visits, most of their charity relief went to individuals in need who approached the sisters directly at the hospital. Dr. Ernest A. Bryant ran a surgical clinic at the hospital on Saturday mornings, and in October 1905, the Daughters opened two new outpatient clinics “for the poor people of the city in need of medical assistance.”

Housed in small cottages on the hospital grounds, the two clinics included a room for those suffering from “ear, eye and throat troubles,” a general medical department for those with other illnesses, and a room where doctors could perform minor surgical operations. The clinics offered prescriptions at one-third the usual rate, although the Los Angeles Herald noted the sisters would dispense medicines for free in “extreme cases.”

Sister Stephanan, recently transferred from Mullanphy Hospital in St. Louis, supervised the clinics, one for men and one for women. Physicians would see patients at the clinics for three hours each morning. By opening the outpatient clinic, the Daughters expanded their medical services for the sick poor. Bed space in the hospital remained valuable, since there were some months where the hospital’s proceeds did not even pay the interest on their construction debts. With the clinic, physicians could treat illnesses and perform minor operations without formally admitting patients to the facility. The Daughters of Charity prioritized care for the sick poor, but continued to balance it with financial realities.

The outpatient clinic enhanced the hospital’s charitable resources, and the sisters still continued to provide inpatient care for the poor persons when needed. Between 1913 and 1930, an average of 5.8 percent of patients received free care at St. Vincent’s Hospital, although the numbers climbed to 9 and 10 percent in 1918 and 1919, respectively (table 5.12, appendix A). Partial payment over the same time period averaged 7.3 percent, although that figure is skewed because the sisters did not record any partial payments for the five years between 1917 and 1921. Fourteen percent of patients made partial payments in 1915, while the numbers hovered around 10 percent in the early 1920s. The percentage of patients paying only part of their bills skyrocketed in 1928 and 1929, reaching over 30 percent. The persistence of free and part-pay patients suggests an ongoing commitment to provide medical care for the sick poor, but the numbers of part-pay patients also suggests the sisters promoted personal responsibility by encouraging patients to pay what they were able. The hospital was not so well-funded that it could completely ignore the bottom line. Paying patients still averaged 86 percent of those receiving care in the hospital between 1913 and 1930. While maintaining a commitment to charity work, the sisters continued their mixed-use economic strategy from the nineteenth century, using the fees of private patients to subsidize treatment for those who could not pay their bills.

According to the annual reports, however, hospital patients were not the only ones receiving assistance from the Daughters of Charity in the early twentieth century. Between 1913 and 1930, the sisters reported assisting 22,359 individuals (table 5.13, appendix A). The “Poor Relieved at the House” averaged twenty-eight individuals per week, or 1490 individuals per year. Although not defined, this assistance may have included food, medicine, first aid, or referrals.

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387 “Establish Free Clinic at Sisters’ Hospital,” Los Angeles Herald, 24 September 1905.
388 “Sisters to Care for Needy Sick,” Los Angeles Herald, 30 September 1905.
to other places where individuals could receive further assistance. Until 1927, the sisters remained on the seventeen-acre site on Sunset Boulevard. In addition to the hospital, they maintained a chicken ranch, raised cattle, and cultivated a vegetable garden. They had food to give. Even though the details remain sketchy, poor individuals clearly saw St. Vincent’s Hospital as a ready resource where they could obtain assistance. In 1919, the sisters provided charitable assistance to 1525 individuals, excluding any free or part-pay patients treated at the hospital. The total number of patients admitted that year was 1995, so the sisters’ outside charity work amounted to the equivalent of three-quarters of their annual patient population. Charity work formed a significant aspect of hospital operations.

The timing of the peak needs for this type of charitable assistance provides some important clues about the economy and conditions for the poor. The number of people needing relief jumped dramatically as the United States entered World War I. In 1917, 1380 individuals received assistance from the hospital sisters, and the numbers continued to climb throughout the war. Approximately 1500 people also received assistance from the sisters each year during the post-war recession (1919-1921). As a result of the influenza epidemic and the recession, over 400 people sought free hospital care in 1918 and 1919, which amounted to approximately 10 percent of the total patients. The increased demand for relief rose chiefly from the rapidly rising cost of living in the city. In February 1919, the National Industrial Conference Board (NICB) reported that the cost of living for a “workman and his family of four” had increased 68.1 percent nationwide between 1914 and 1918. Food increased 83 percent, and shelter rose 20 percent; prices for fuel, heat, and light increased 55 percent; clothing prices jumped 93 percent and the cost of sundry items such as car fare increased 55 percent. The NICB reported that working families spent 43 percent of their income on food, 18 percent on shelter, 6 percent on fuel, 13 percent on clothing, and 20 percent on sundry items. If individuals needed food, medicine, medical care or other assistance for a sick loved one, it would be reasonable to seek out the hospital sisters. By providing such assistance, the Daughters of Charity continued “their primary and principal duty” to serve the sick poor in the early twentieth century.

395 Ibid.
394 Ibid.

CONCLUSION

By purchasing Beaudry Park in 1883, the Daughters of Charity embarked on a path of medical modernization. The site housed two hospitals, each representing the sisters’ best efforts to adapt to the needs of physicians, private patients, and poor persons who lived in Eastern Los Angeles. After World War I, the Daughters continued to improve hospital operations and patient care to remain a leader in an increasingly competitive market. When the Catholic Hospital Association (CHA) endorsed the standardization movement spearheaded by the American College of Surgeons in 1917, the Daughters implemented practices that would meet the organization’s standards. After a visit from CHA president Charles B. Moulinier, S.J., St. Vincent’s Hospital adopted standard record-keeping and laboratory procedures, including maintaining patient medical histories, requiring blood and urine tests for all patients on admission, and holding regular staff meetings to discuss potential improvements for hospital policies and procedures. Dr. Edward T. Dillon also explained that the Medical Staff established a committee to investigate “unwarranted complications” during a patient’s recovery, in hopes of improving hospital practices. As a result of these changes, the American College of Surgeons included St. Vincent’s among the first group of nationally-accredited hospitals in 1920. In the early twentieth century, the Daughters of Charity continued to adapt the best old traditions to the best new, and in so doing they maintained an economically viable, modern scientific institution without losing the heart of their religious mission.

397 Kauffman, Ministry and Meaning, 176-178; Edward T. Dillon, “The Story of St. Vincent’s Hospital, Los Angeles,” Hospital Progress 1:7 (1920), 278.
398 Dillon, Ibid., 279.
399 The other Daughters of Charity hospitals in California, Mary’s Help Hospital (San Francisco) and O’Connor Sanitarium (San Jose), were accredited during the same year. “General Hospitals 100 Beds or More,” Bulletin of the American College of Surgeons 4:4 (1920), 27.
The professionalization of nursing in the late nineteenth century challenged the traditional methods, practices, and authority of Catholic hospital sisters. Like other religious communities, the Daughters of Charity developed most of their expertise through informal apprenticeships—learning while doing. In the 1840s, Sister Matilda Coskery’s training manual *Advices Concerning the Sick* blended the science of the day with the “religious art of nursing,” and as part of their tradition, the Daughters remained attentive to both physical manifestations of sickness and the spiritual needs of patients.400 As Martha M. Libster and Betty Ann McNeil, D.C., argue, “*Advices* imparts a holistic philosophy of nursing, addressing the corporal, mental, emotional, and spiritual needs of patients.”401 The sisters retained a holistic approach to patient care in the late nineteenth century, and the Daughters of Charity continued to produce highly skilled nurses through apprenticeship programs. However, these training opportunities did not provide diplomas, certificates, or other recognized evidence of professional status until the 1890s. As vowed women, sisters did not take salaries, and this further reinforced their non-professional status. But most importantly, hospital and nursing reform advocates portrayed their methods as alternatives to the “backwards” traditions of religious communities.

Instead, reformers hailed Florence Nightingale as the hero of modern nursing. As historian Susan M. Reverby characterizes it, Nightingale’s philosophy “was built on an uneasy alliance among concepts drawn from the sexual division of labor in the family, the authority structure of the military and religious sisterhoods,

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401 Libster and McNeil, *Enlightened Charity*, 163. For more on nurses’ education through religious service, see *Enlightened Charity*, 35-82.
by physicians and other specialists at Mount Hope, near Baltimore. Sister-nurses attended these lectures, and by 1892, Mount Hope had developed a sisters-only diploma program. On 20 April 1892, Mother Mariana Flynn consulted with several administrators of the sisters’ hospitals in the eastern United States, and they decided to move forward and develop nurses’ training schools for lay women.406

Once the decision was made, the Daughters moved quickly to adapt to changes in the marketplace. While the first Nightingale-inspired training schools had opened in New York, New Haven, and Boston in 1873, Christopher J. Kauffman notes that only fourteen training schools existed in the United States twenty years later. Half of them were operated by the Daughters of Charity. The training school movement really took off in the 1890s, and 422 hospitals operated training programs by the end of the century. Although not the first to open a formal training school, the Daughters embraced the training school movement and operated on the leading edge of the hospital industry. Training programs for both sisters and lay women spread to their institutions throughout the country, and by 1910 the sisters ran twenty-seven nursing schools, including one in Los Angeles.407

Nursing schools served several purposes for the Daughters of Charity. First, they expanded the labor force of the growing hospital. According to a 1926 account, the first students worked up to sixteen hours per day: making beds, delivering meals, and scrubbing the operating room floor. Importantly, the history notes “the Sisters had to work equally as hard as the nurses,” thereby avoiding any intimation that the sisters exploited their workers.408 The Daughters expected students to work as hard as they did, reinforcing their commitment to discipline and vocation. Besides increasing their workforce, student nurses also improved a hospital’s professional image, emphasizing scientific medicine and professionalism. In addition, the training school provided career opportunities for single women, thus fostering their economic independence and hopefully preventing more families from slipping into poverty. But most importantly, nursing schools offered the Daughters an avenue through which to preserve their mission of charitable service. The schools not only taught academic subjects like biology and physiology, but they also trained young women on the sisters’ traditional approach.


405 Clark, A History of Good Samaritan Hospital, 37.

406 Hannefin, Daughters of the Church, 170-172; Richardson, A History of the Sisters of Charity Hospital, Buffalo, 131.

407 Kauffman, Ministry and Meaning, 161; Hannefin, Daughters of the Church, 171; Lewenson, Taking Charge, 23, 27. Although it took some time for the training movement to spread throughout the sisters’ institutions, Sister Eugenia Fealy instituted a course for the sisters to update their scientific nursing skills in October 1895, four years before opening a lay training school. Fealy to Flynn, 20 October 1895.

408 La Marillac: The Second Annual of the St. Vincent’s Hospital School of Nursing, 44.
towards patient care. Nursing schools allowed the Daughters of Charity to adjust to the changes in American medicine without giving up the core of their mission.

NURSES' TRAINING IN LOS ANGELES

The nurses' training movement arrived in Los Angeles in 1895, when Dr. David C. Barber convinced the Los Angeles County Board of Supervisors and members of the Friday Morning Club to support a training school at County Hospital. Barber persuaded the supervisors to support the venture on economic grounds, arguing that “skilled attendance could thus be secured for the patients without any additional expense to the county.”

The thirty clubwomen who volunteered to join the school's Ladies' Board of Supervisors, likely did so for a combination of reasons, including business interests, civic duty, and progressive-minded woman's activism. At least two of the managers, Louise Puett Lindley and Elizabeth Holler Moore, were physician's wives; trained nurses would advance each of their husband's business interests.

A training school also enhanced the city’s “modern” image, as it improved the quality of the community's social services. But most importantly, nurses’ training offered educational and professional opportunities for young women, an ideological goal that the clubwomen supported—particularly in the midst of the 1896 suffrage campaign.

County’s program, officially called the College Training School for Nurses, set the standard for other programs which quickly sprouted up in Los Angeles. Although the hospital may have started accepting students sometime in 1895, sixteen physicians volunteered to teach free lectures in anatomy, physiology, and other relevant subjects in 1896. Dr. Francis Haynes also wrote a textbook for nurses in the program. The Primer of Surgical Nursing was published in 1895, and presumably used during the following year.

Students received “practical training” under the supervision of experienced nurses while they worked in the hospital's wards. The students exchanged room, board, and training for an estimated sixty hours of labor per week.

In 1897, nursing applicants were only required to have a grammar school education, and they had to be between the ages of twenty-one and thirty-five. Like other training schools throughout the nation, the program required that applicants be in good health, and “of good moral character.”

In 1896, suffragists engaged in a statewide campaign to secure the vote for women in California. In Los Angeles, supporters sought to reach out to men and women of all classes, holding noontime meetings for factory workers and teas for middle-class clubwomen. The measure passed in Los Angeles, but strong opposition from the liquor industry led to its defeat in San Francisco and Oakland. Liquor industry leaders worried that if women got the vote, it would lead to prohibition. Because the majority of the state's population lived in San Francisco, its defeat there meant that the measure failed in the state. Women did not receive the vote in California until 1911.

Los Angeles Times, 15 July 1896; “Opening Exercises Program, College Training School for Nurses.”

Although the exact workload at County Hospital is unknown, Charles Rosenberg notes that in the 1890s student nurses elsewhere generally worked on the wards sixty to seventy hours a week. Rosenberg, The Care of Strangers, 221; “First Class Graduates from the College Training School,” Los Angeles Times, 9 June 1897. See also “College for Nurses,” Los Angeles Times, 4 August 1896; “Trained Nurses,” Los Angeles Times, 15 July 1896; “Opening Exercises Program, College Training School for Nurses.”
Including a two-month probationary period, the course of instruction lasted two years, during which students attended a series of medical lectures and completed their required “hospital service.” Lectures included discussions of pregnancy, labor, and care of infants; anatomy and physiology, hygiene, and the symptoms of various diseases; as well as practical skills like cooking, massage, and use of medical appliances. Physicians gave two to six lectures on each topic, depending on complexity, and student nurses spent the remainder of their time working in a “recognized” hospital, in this case the Los Angeles County Hospital. Twelve students graduated in the first class in June 1897.415

Seeing the advantages of this new system, other hospitals quickly followed County’s example. Originally, the Hospital of the Good Samaritan agreed to support the College Training School for Nurses, but conflicts over student labor quickly emerged and administrators determined that each hospital should have its own program. Good Samaritan graduated its first class of nurses in July 1898, and California Hospital graduated its first class in June 1899.416 The Daughters of Charity accepted their first students that same year. The opening of California Hospital’s training school caused a shake-up among the original group of supporters who instituted nurses’ training in Los Angeles. California Hospital’s nursing program was supported by some of the leading members of the Los Angeles County Medical Association, including Walter Lindley, Joseph Kurtz, and George W. Lasher. By 1900, the leadership of the Ladies’ Board of Managers switched from the College Training School to California Hospital. Mrs. T.B. Brown, Mrs. F.T. Griffith, Miss M.F. Wills, Mrs. Walter Lindley, Mrs. E.P. Johnson, and Mrs. Melvin L. Moore directed the College Training School in 1898, and then directed California’s training school in 1900. Two of these women’s husbands, Dr. Walter Lindley and Dr. Melvin L. Moore, were part of the driving force behind the establishment of the physician-led California Hospital, so these women probably followed their husbands’ business interests and drew their social contacts with them. However, it appears that at least some of the physicians may have continued to give lectures for students at both schools, since Dr. Joseph Kurtz spoke at the College Training School’s graduation exercises in 1900.417

When the Reverend Robert A. Lennon, C.M., Director of the American Province of the Daughters of Charity, recommended that Sisters’ Hospital establish a nursing school in Los Angeles in 1899, Sister Eugenia Fealy felt assured that the sisters could attract students, but she worried about finding “good Doctors” to give the required lectures. Two of Sisters’ Hospital’s most respected physicians, Dr. Francis K. Ainsworth and Dr. Ernest A. Bryant were stockholders in California Hospital, and Sister Eugenia assumed they would also teach there. Dr. M.M. Kannon struggled with a morphine addiction and was in no condition to instruct students. Sister Eugenia knew that “we don’t want second class Doctors,” but she decided to go forward in faith: “I am going ahead with the work, my dear Mother, trusting that our dear Lord in his own time will supply other necessaries.”418 And so the Daughters did open their training school in 1899, although it is unclear who provided the medical instruction.

Although the school remained small in its early years, St. Vincent’s Hospital School for Nurses steadily grew. Initially, the school only had three graduates, but

415 Ibid.

416 “Trained Nurses Graduate,” Los Angeles Times, 4 June 1898; “City Briefs,” Los Angeles Times, 28 June 1899; “Four Nurses Graduate,” Los Angeles Times, 30 June 1899; Clark, A History of Good Samaritan Hospital, 22.


418 Fealy to Flynn, 25 June 1899. Emphasis in the original.
by 1905, the graduating class increased to nine. By 1916, the graduating class numbered fifteen nurses, and by 1929, the class size had increased to twenty-four. The graduating class did not number more than forty until after World War II.\(^{419}\) Even though the graduating classes remained small, the total size of the student body grew during the 1910s and 1920s, averaging fifty-eight students between 1917 and 1924, and ninety-eight students in 1930.\(^{420}\) The sisters kept pace with professional standards, conforming to state-approved curricula and reducing student nurses’ workweeks to forty-eight hours in 1913. Twenty-one graduates served in Italy during World War I, including Olive Heath and Nell Hurley McGrath who received a Gold Star.\(^{421}\) All students were supervised by registered nurses, many of whom were Daughters of Charity or graduates of the sisters’ school.

**THE DAUGHTERS’ APPROACH TO NURSES’ TRAINING**

The training school for nurses reflected a cooperative approach between the sisters, hospital, and students. The Daughters of Charity provided food, housing, laundry service, health care, academic instruction, and practical training to students in exchange for their labor at the hospital. Students did not pay tuition until the 1940s, although by 1925 they were required to purchase textbooks for fifteen dollars, provide a twenty-five dollar deposit for two uniforms, and bring the necessary school supplies (the most important of which was a pocket watch with a second hand).\(^{422}\)

In 1945, the Daughters lost money on each student, but the nursing school still served to address the hospital’s labor needs, to reinforce its professional, scientific image, and to share the sisters’ conceptual approach to the vocation of nursing.\(^{423}\)

\(^{419}\) “Golden Jubilee of St. Vincent’s School of Nursing Program, 1899-1949,” 1949, 25-32, College of Nursing Collection, Box 3, Folder 23, SVMCHC, Los Angeles.

\(^{420}\) “Financial and Statistical Statements, 1913-1945.”

\(^{421}\) “Golden Jubilee of St. Vincent’s School of Nursing Program,” 16, 24.

\(^{422}\) Sister Mary Ann Keating considered instituting tuition charges in 1934, but a student handbook printed in either 1940 or 1941 still does not list any tuition, although there are some fees for student health examinations, uniforms, and books. The first instance where tuition charges are reported is in a 1945 survey conducted by the U.S. Public Health Service; it was recorded as fifty dollars for the 1944-1945 academic year. Louis Block, “Cost of Nurse Education at St. Vincent’s Hospital School of Nursing, Los Angeles, California,” 7 May 1945, College of Nursing Collection, Box 3, Folder 13, SVMCHC, Los Angeles; Mary Vincent, D.C., to Mary Ann Keating, D.C., 15 July 1934, *Ibid.*; Sister Roberta to Mary Ann Keating, D.C., 15 July 1934, *Ibid.*; “Handbook, St. Vincent’s Hospital Training School for Nurses,” c. 1925, 13, Nursing School Display, SVMCHC, Los Angeles.

\(^{423}\) In 1945, St. Vincent’s Hospital School of Nursing spent $2845.15 on each student over her three-year course of study. These costs included food, housing, salaries for instructors (either actual salaries for lay instructors or the equivalent for sister-instructors), laundry, equipment breakage, and costs associated with building maintenance and depreciation. Students paid $2754.70 in fees during the program (including $50 per year in tuition), so the Daughters of Charity lost $90.45 on each student.
the perpetuation of their religious community’s approach to nursing by placing experienced leaders at the helm. In 1914, Sister Estelle Becker served as Superintendent of Nurses in Los Angeles, before exchanging places in 1917 with Sister Ann O’Connor, the superintendent of the nursing school at St. Joseph’s Hospital in Chicago. Sister Estelle had ten years of experience at hospitals in Birmingham and El Paso before coming to Los Angeles, and Sister Ann had seventeen.428 However, provincial leaders eventually appointed a young Irish-Canadian graduate nurse named Sister Helen McMahon as Director of Nursing in 1920. Although only twenty-four years old, Sister Helen represented the efforts of the Daughters to place graduate nurses in leadership positions within their hospitals and nursing schools. After receiving her nurses’ training in Canada, Helen McMahon came to the United States with her sister Edith in 1917, probably with the intent of becoming a Daughter of Charity. Before finishing her seminary training she was sent to Milwaukee by her superiors to be “trained by Sister Stephanie, who was considered to be a perfect Directress of Nurses.”429 Sister Helen’s first assignment as a Daughter was as Director of Nursing at St. Vincent’s Hospital in Los Angeles, and she remained in this position until 1948. Incidentally, Sister Mary Ann Keating, the hospital’s administrator from 1904 to 1941, was also a registered nurse. Sister Helen had several years of experience on the floors, but she and her students would also benefit from Sister Mary Ann’s tutelage. By 1920, Keating had thirty years of experience as a hospital administrator and nurse, and she kept the institution’s focus on quality nursing care.430

As nursing school curricula became more standardized in the 1920s, the Daughters of Charity adapted their programs to state standards and industry expectations, while continuing to maintain an attitude of Christian service. Between 1900 and 1930, reformers sought to bolster nurses’ professional status by raising the educational qualifications and instituting state licensing requirements. Since most graduate nurses went into private-duty work, rather than continuing to work in a hospital, many cities offered “registries” or employment agencies where potential clients could be referred to an appropriate nurse. Sponsored by training school alumnae associations, physicians’ groups, or commercial agencies, registries acted as a form of self-policing for the profession. The agency set the required standards for a “registered” nurse to get work.431

However, leaders in nursing education such as Lavinia Dock remained acutely aware of the wide range of student experiences in hospital training schools. They worried that some students lacked the appropriate skills and scientific knowledge for what they deemed quality nursing, thereby diluting the professionalism of the entire field. These reformers sought to standardize nursing education through state licensure requirements. The California legislature passed the Nurses’ Registration Act in 1913, establishing the Board of Nurse Examiners

428 “Financial and Statistical Statements, 1913-1945”; Huber, “A History of St. Joseph School of Nursing,” 35-36. O’Connor had extensive nursing experience, and had worked in hospitals in Buffalo (1900); St. Joseph, Missouri (1904); Boston (1905); Washington, D.C. (1905); Birmingham (1906); Montgomery (1912); and Chicago (1914); before coming to Los Angeles (1917). “Ann O’Connor, D.C.,” entry in Daughters of Charity Database, APSL. Accessed 10 February 2012. Becker served in St. Vincent Hospital, Birmingham (1904), Hotel Dieu in El Paso (1907), and St. Joseph’s Hospital in Chicago (1914), before coming to Los Angeles (1917). “Estelle Becker, D.C.,” entry in Daughters of Charity Database, Ibid.

429 Mary Vincent Foley, D.C., “Reminiscences About Sister Vincent Murphy,” n.d. Included in Helen McMahon, D.C., Personnel Files, APSL.

430 “Helen McMahon, D.C.,” entry in Daughters of Charity Database, APSL. Accessed 10 February 2012; [McMahon], “This I Remember”; “Sister Helen McMahon [Helen Marguerite McMahon], U.S. Naturalization Record,” 16 October 1933, Naturalization Records of the U.S. District Court for the Southern District of California, Central Division (Los Angeles), 1887-1940, Microfilm Serial M1524, Microfilm Roll 176, National Archives and Records Administration, Washington, D.C., available through ancestry.com; “Mary Ann Keating, D.C,” Entry in Daughters of Charity, Consolidated Database (10-0) APSL.

431 Susan Reverby, Ordered to Care, 103-104.
under the supervision of the State Board of Health. The board developed educational standards for training school curricula, and examinations for students to take upon graduation. If she passed, a nurse’s name would then be added to the state registry.432 By 1920, the state had legitimized the title “registered nurse,” and the most prestigious hospitals and training schools sought to employ registered nurses on their staffs. Even so, licensing requirements varied from state to state, and registration remained voluntary in California until 1939. However, training schools built their reputations on the ability to meet state standards. Small schools that could not meet the accreditation requirements were often forced to close, and these included nearly half of the hospital training schools in California.433

As part of the registration movement, classroom preparation for student nurses began to take on more importance in the 1920s and 1930s. Like other programs, the sisters’ school in Los Angeles balanced “theoretical instruction” and “practical work.”434 Hospital physicians conducted the science courses and the sister-nurses supervised students’ work on the floor. Although originally two years in length, the nurse’s training course was extended to three years in 1908, reduced to twenty-eight months in 1921, and re-extended to three years in 1925.435 By 1925, the three years of training included a four-month preparatory period in which students received intensive academic instruction in chemistry, anatomy and physiology, bacteriology, hygiene, nutrition, and nursing procedures. The probationary students, nicknamed “probs,” spent four hours in class each morning, and four hours at the hospital doing “practical work” in the afternoon. Second and third-year students spent fewer hours in classroom instruction, eighty-six hours for juniors (second-year) and seventy-six hours for seniors (third-year), compared with 208 hours of classroom instruction for probationary students.436

At the end of the regular twenty-eight-month course, the training school offered four to eight-month specialty courses in surgery, obstetrics, or administration. The school also offered a one-month program in “social service work” at the Santa Rita Clinic, where nurses could gain public health experience.437 Funded by the Bureau of Catholic Charities, the Santa Rita Clinic provided medical and dental examinations for child welfare applicants, and outpatient care for needy families.438 Students, therefore, were offered a broad-based curriculum and opportunities to intern in various aspects of their professional field.

Although academic training remained important, much of the sisters’ instruction remained on the day-to-day practical work of nurses, what is now called clinical training. Beginning students learned how to make beds, serve meals, clean hospital equipment, give bed baths, take patient’s vital signs (temperature, pulse, and respiration), and keep accurate medical records. More advanced students observed surgery and childbirth, and had greater responsibility to care for patients on the floors. Student’s instruction in practical work followed the apprenticeship patterns developed by generations of Daughters of Charity, including the development of technical expertise along with proper demeanor and attitude towards her work. However, unlike in the early days of the school, students received closer supervision and more opportunities for feedback in the 1920s. In Chicago, students received reports, “advice[,] and admonitions” from their department heads as well as the Director of Nursing. In her history, Sister Zita Huber asserts that “this elaborate check up on the work of students” greatly reduced the number of failures among them.439 In Los Angeles, the Daughters hired Nettie Fisher as a nursing instructor and Beatrice Grant to supervise the obstetrical department, but sisters supervised the operating room, pharmacy, laboratory, and patient floors. Fisher and Grant were both graduates of the training school, and they would be thoroughly acquainted with the hospital’s work culture and the sisters’ approach to nursing. All of the sisters in supervisory positions were registered nurses, or had another appropriate designation, thus reinforcing the professional status of the sister-nurses and their school.440 The extension of theoretical work, the closer


433 Between the initial passage of the registration act in 1913 and the Nurse Practice Act, which made registration mandatory, in 1939, forty-two of the eighty-one training schools in California closed. D’Antonio, American Nursing, 115; Haig, The Development of Nursing, 2.

434 Melosh, The Physician’s Hand, 44.

435 The First Annual of the St Vincent’s School for Nurses, Los Angeles, 80.


437 Ibid., 7; Edward M. Pallette, Ph.D., M.D., “Address of the President of the Staff at the Opening of School, 15 September 1924,” in The First Annual of the St Vincent’s School for Nurses, 29.

438 “Golden Jubilee of St. Vincent’s School of Nursing Program,” 17.

439 Huber, A History of St. Joseph School of Nursing,” 44–45.

440 Nettie Fisher, R.N., graduated from St. Vincent’s Hospital Training School for Nurses in 1916. She served as a nurse during World War I before returning to the hospital as a paid Instructor of Nurses. Beatrice Grant graduated from the sisters’ school in 1918. She also served during World War I, although it is not known in what capacity. The sisters also hired Elizabeth Blackwood and Mae McDer- mott to work in the obstetrics department. Both were registered nurses, but not students at the sisters’ school. “Handbook, St. Vincent’s Hospital Training School for Nurses,” 5. Interpretations of a sister’s vow of chastity greatly complicated the incorporation of obstetrical departments in Catholic hospitals, and presumably this is the primary reason that Daughters of Charity did not supervise the obstetrics department at St. Vincent’s. For further discussion of the ways that Catholic sister–nurses approached
supervision of students’ practical training, and the inculcation of Vincentian values through the mentoring of sister-nurses allowed the Daughters of Charity to continue their holistic approach to nursing into the twentieth century. The sisters’ philosophy and practices balanced scientific medicine with spiritual healing.

In the early twentieth century, nurses’ training represented both an educational endeavor and a labor arrangement. Although the hospital considered them “in no sense wages,” students received monthly allowances for personal expenses. In the 1910s, first and second-year students received five dollars per month, while third-year students received eight dollars. In 1920, the student nurses’ allowances increased: eight dollars per month for first-year students, eleven dollars for second-year students, and third-year students received fifteen dollars per month.\(^441\) The Daughters of Charity recognized that students would have some incidental expenses, but they considered education “a full equivalent for all services rendered by the students.”\(^442\) In Chicago, the students at St. Joseph’s received similar stipends; however, they never received the amount in cash. In 1910, St. Joseph’s deducted their tuition from the stipend, and by 1939, students’ allowances were transferred to an “Education Fund which pays the instructors, buys student books, and cares for all expenses attached to the laboratories.”\(^443\)

The Daughters of Charity clearly defined the relationship between student and hospital. Students were not employees and did not receive salaries. Students received education and training in exchange for their services. In this way, the sisters avoided any accusations (and potential legal complications) about exploiting workers. But at the same time, the Daughters kept their costs low and made nursing schools accessible to all classes of students. In Los Angeles, St. Vincent’s Hospital did not charge students tuition until 1943. Even in Chicago, where tuition was instituted much earlier, the initial amount was equivalent to six months of a first-year student’s stipend.\(^444\) No cash was required up front, and any qualified student could enter the program.

While the Daughters of Charity did not consider their nursing students hospital workers, student benefits roughly amounted to what the state of California considered a living wage for a single young woman. In 1914, student nurses received instruction, food, housing, uniforms, and laundry service as part of their training, as well as a monthly stipend of five to eight dollars, depending on experience level. The Industrial Welfare Commission (IWC), a progressive agency intent on protecting the rights of women workers, determined that the “minimum proper cost of living” in 1914 for self-supporting women without dependents was $9.63 per week ($38.52 per month), although the cost of living for sales and office workers in Los Angeles was slightly less at $8.68 per week ($34.72 per month).\(^445\) The commission also reported that nearly half (49.1 percent) of working women over eighteen made less than $10.00 per week.\(^446\) If we use IWC numbers to calculate the value of the student nurses’ benefits, room and board equated to $22.12 per month, laundry and incidentals equated to $6.16 per month. Excepting uniforms (a one-time cost), student benefits amounted to $28.28 per month without the students’ monthly stipend.\(^447\) In 1914, second- and third-year students received $8.00 per month as a stipend, raising their benefits to $36.28, or just over the IWC’s estimate for the cost of living for a saleswoman or office worker in Los Angeles. State law also limited student nurses to working eight hours per day, and required hospitals to give students one day off per week.\(^448\) While the demands were rigorous, the benefits remained competitive, and the sisters’ training school provided a viable economic option for young women seeking to support themselves, as well as preparing them for future employment.


\(^443\) Huber, “A History of St. Joseph School of Nursing,” 41.

\(^444\) When instituted in 1910, tuition at St. Joseph School of Nursing was thirty dollars annually. As a stipend, first-year students received five dollars per month, second-year students received eight dollars per month, and third-year students received ten dollars per month. \(Ibid.\), 40.
Deceased
Became a Daughter of Charity
Single in 1925
Married by 1925
Single at time of graduation
Married at time of graduation

February 1919.


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Compiled from The First Annual of the St. Vincent’s School for Nurses, Los Angeles, 1925. College of Nursing Collection, Box 3, Folder 27. St. Vincent Medical Center Historical Conservancy, Los Angeles. Table created by the author.

Compiling a profile of graduates from admissions requirements, census records, and graduation lists provides some insight into the type of women attracted to the nursing school and the opportunities it provided. In 1918, the California State Board of Health required all applicants to have a high school diploma, including four years of coursework in English, two years of household arts and home sanitation, and one year of biology and chemistry. The board also recommended that students take one year of physics, sociology, and a foreign language.449 St. Vincent’s complied with these requirements, and the school accepted young women between the ages of eighteen and thirty-five who had an appropriate educational background, good health, and solid personal references.

Most nursing students were single at the time of graduation, and of those women who graduated between 1911 and 1920, over 40 percent remained single in 1925 (see table 6.1). Some students used nursing school as an interlude between high school and marriage, while others embarked in the field as a path to economic independence. Of the forty-six nurses listed on the 1920 census, 76 percent were born in the United States, although over a third of those young women were the daughters of Irish, German, French, Swedish, and Bohemian immigrants. The remaining nurses were immigrants from Canada, Ireland, Norway, Poland, Sweden, and Switzerland. Although one of the school’s first graduates, Lolita Cordona, had some Latin American heritage, only three other students of Mexican descent graduated from the school before 1932. Irene Montana, the daughter of Mexican immigrants to Arizona, graduated in 1928, Adelaide Dominguez graduated in 1929, and Onesima Lopez, born in New Mexico, graduated in 1931. According to the 1930 census, Elena Castelrigo, a Mexican immigrant, also attended the school, but apparently did not complete the course of study.450 Mexican women were clearly underrepresented at St. Vincent’s.

White women dominated the rolls of all Los Angeles nursing schools in the early twentieth century. In 1910, the Hospital of the Good Samaritan had no nurses who claimed Mexican descent or had identifiable Spanish last names. According to the 1920 census, California Hospital only had two students of Mexican descent, Teresa Josephena de la Cuesta and Eloisa Martinez; Consuela F. Quint attended the Clara Barton Hospital School of Nursing; and Rose Melendras and Dolores Ramirez were listed among the nurses at County Hospital, although it appears that Ramirez did not graduate.451 The local chapter of the National Association for the Advancement of Colored People began lobbying for the admission of black students to County Hospital’s nursing school in 1911, but the Board of Supervisors did not respond favorably to their petitions until 1918. On 17 July 1918, the board unanimously voted to admit African American women to the school on the same terms as other qualified applicants.452 White students vehemently protested, on the grounds that new students would have to give deference to black nurses since “the discipline of the

[449] “Golden Jubilee of St. Vincent’s School of Nursing Program”; U.S. Census, Los Angeles, 1910; U.S. Census, Los Angeles, 1930. In 1926 Irene Montanta also played saxophone in the nursing school’s jazz band. College of Nursing Photo Collection, HC 026, Box 14, Folder 4, No.156, SVMCHIC, Los Angeles.

[450] U.S. Census, Los Angeles, 1910. Teresa Josephena de la Cuesta, whose parents were both born in California, graduated from California Hospital’s nursing school in 1920. Eloisa Martinez, a twenty-three-year-old immigrant who came to the United States from Mexico in 1914, also attended the school in 1920. Consuela F. Quint likely came from a bicultural family. Her mother was from California and her father came from Vermont. Rose Melendras and her parents were born in New Mexico, and she declared Spanish to be her native language. Melendras graduated in 1922. Dolores Ramirez immigrated to the United States from Mexico in 1919. U.S. Census, Los Angeles, 1920. “Nurses to be Given Diplomas: Three Hospitals Will Hold Joint Graduation Tonight at Gamut Clubhouse,” Los Angeles Times, 12 May 1922; “Nurses Graduate Tonight: Seventy-five to Receive Diplomas From Los Angeles General Hospital School, World Well Represented by Graduating Nurses,” Los Angeles Times, 7 June 1923; “Nurse is Queen in Los Angeles: National Hospital Day Given Initial Observance; Commencement Exercises Are Inspiring Feature; Eighty-one Graduates Pledge Lives to Humanity,” Los Angeles Times, 13 May 1921. Note: the census-taker did not distinguish between student and graduate nurses at County Hospital, so it is possible that Ramirez was not a student, although this is somewhat unlikely considering that most of the nursing staff attended the training school.

language deficiencies, regardless of their proficiency in English. Historian George J. Sanchez also notes that IQ testing resulted in labeling many Mexican students as “slow,” and secondary schools often tracked these students into vocational programs which emphasized manual labor. In at least one case, guidance counselors denied Mexican American students opportunities to transfer to academic tracks in an effort to pursue nursing careers.455 Although not impossible, fewer young women of Mexican descent may have had the opportunity to receive the required academic preparation for nursing school. Cultural factors may have also discouraged traditional Mexican parents from allowing their unmarried daughters to live away from home and care for strangers, many of whom would be men.

The Daughters of Charity combined scientific instruction, practical experience, and an attitude of service in their nursing program. But exposure to the sisters, and their way of life, also produced a spiritual awakening in some students. In 1925, Sister Mary Ann Keating reported that two of her nursing students were “taking instruction,” or studying to become Catholics. Another wished to become a sister, although she had only converted to Catholicism two years previously. Sister Mary Ann decided to “put her off for a little while.”456 Before joining the community, the sisters wished postulants to fully understand their religion and be prepared for life as a Daughter. From Sister Mary Ann’s perspective, a postulant needed “to understand very well that her life as a Sister of Charity will be one of sacrifice and self-denial… [and] prove faithful to the ideals that are hers.”457 But as this letter demonstrates, the nursing school served both secular and spiritual purposes. Six nursing students became Daughters of Charity between 1909 and 1923.458 Operating a nursing school was not an incredibly productive recruiting institution required a junior nurse to step aside and give the senior nurse the right of way in all respects while on duty.”453 Even though 126 student nurses threatened to resign at the height of the influenza epidemic of October 1918, the supervisors did not relent. By September 1919, four African American women were admitted to the school, although they were assigned a separate dining table and living quarters. The number of black students remained low throughout the 1920s, but forty-six black women did graduate from the school by 1933.454

The dearth of Mexican, Mexican American, or Califorina students may have resulted from overt discrimination by Los Angeles nursing schools, from structural racism which reduced the number of young women seeking to enter the field, or from both. In the early 1930s, one scholar estimates, 53 percent of Mexican girls left school between ages fourteen and sixteen. At the elementary school level, students with Spanish last names were often funneled into segregated (and frequently inferior) Mexican schools because of assumed

453 “Says Hospital Faces Crisis,” Los Angeles Times, 16 October 1918.

454 Looking Back – A Century of Nursing, 77; “Protests of Nurses May Be Ignored,” Los Angeles Times, 30 July 1918; “Says Hospital Faces Crisis”; “Nurses Won’t Walk Out Now,” Los Angeles Times, 29 October 1918.

455 Sanchez, Becoming Mexican American, 103–105, 257–259. Esperanza Acosta (later known as Hope Mendoza Schechter, a labor organizer) sought to switch out of home economics at Belvedere Intermediate School, so she could prepare to enter nursing school. However, her guidance counselor denied the request, commenting that no one would want to be taken care of by “someone as black as me.”


457 Mary Ann Keating, D.C., to Eugenia Fealy, D.C., 20 July 1927, Ibid.

458 “Golden Jubilee of St. Vincent’s School of Nursing Program,” 23.
tool for the religious community, but as the editor of Tidings commented in 1934, “The aim of the hospital is to make [all] nurses intelligent, virtuous and free, capable of self-guidance and self-control so that all shall lead a holy life.”

St. Vincent’s Hospital Training School for Nurses inculcated students with the sisters’ religious and moral approach to healthcare. Nurses were expected to be cheerful, virtuous, self-sacrificing, trustworthy, and persistent women who loved God and their neighbors. Applicants provided personal references before being admitted, and the sisters expected each young woman “to be exemplary in manners and morals, for from her entrance she is placed in a position of trust, largely upon her own honor and responsibility as far as her conduct is concerned.” The sisters continued to monitor students’ manners and morals while living in the Nurses’ Home, imparting the discipline, propriety, and commitment they expected from their nurses. The nurses were expected to maintain a “neat and orderly appearance” both in their dress, conduct, and living space. The “rising bell” rang at 6 a.m. and the students ate breakfast at 6:30. Beds were to be made and rooms cleaned each morning before nurses reported for duty at 7 a.m., and sisters who supervised the dormitory floors routinely made surprise inspections. The Daughters also expected students to be cost-conscious, always turning out the lights when they left the room, “even for the shortest time.” Roll call likely included morning prayers, and although the Daughters of Charity accepted students from different religious backgrounds, all would be expected to participate. To remain completely focused on their work, students were not allowed to receive visitors or answer personal phone calls while on duty. The structured environment of the Nurses’ Home reflected the discipline that sisters’ deemed necessary to be an efficient nurse.

Although the rules were strict and exact, the school did not maintain an austere atmosphere and allowed for some youthful frivolity. The nurses’ home had a parlor with a piano and radio; some of the nurses formed a jazz band in the mid-1920s; and the school sponsored class parties several times a year. Although nurses had an evening curfew of 10:30 p.m., students received curfew extensions or “late permits” on every holiday so they could enjoy the company of family and friends. Social interactions with doctors, interns, or male hospital staff were strictly prohibited, but some of the students dated men who worked outside the hospital setting.

In the 1927 yearbook, the school calendar proudly noted when one student got engaged. The Daughters of Charity expected nurses to take work seriously, but they also recognized that students were still young women. However, if administrators felt a student was not living up to her responsibilities, or her “spirit [was] found to be antagonistic to the methods of the Institution,” she could be summarily dismissed from the school, even without committing a “special offense compelling her withdrawal.” Attending St. Vincent’s Hospital

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459 “For Three Centuries the Sisters of Charity Have Served Suffering Humanity,” Tidings, 14 December 1934.


461 Ibid., 8.

462 Ibid., 14.

463 In Chicago, Catholic students were encouraged to attend daily mass after morning prayers, although they were only required to go to mass on Sundays. Non-Catholic students were also required to attend their churches each Sunday. Catholic students were also expected to make confessions once a month to a priest at one of the city’s churches. Huber, “A History of St. Joseph School of Nursing,” 44-47. Although these requirements were not included in the nursing school handbook in Los Angeles, they may have been informal practices.


465 La Marillac: The Third Annual of the St. Vincent’s Hospital School of Nursing (1927), 51-53, College of Nursing Collection, Box 3, Folder 29, SVMCHC, Los Angeles.

School for Nurses was a privilege, and nurses were expected to humbly submit to their superiors so they would fully benefit from what was being offered.

**CONCLUSION**

While nurses were not expected to become Daughters of Charity, the sisters’ schools consistently taught the value of a service-oriented life. In September 1924, Dr. Edward M. Pallette, Sr., the president of St. Vincent’s Hospital Medical Staff, addressed incoming students and outlined the school’s philosophical approach towards nursing. He advised students to choose their “life work” wisely, and to develop the necessary character traits he believed defined a successful nurse, which included health, intelligence, good judgment, and integrity. By situating the students’ training as their “life work,” Pallette conceptualized nursing so it could fit into the religious framework of vocation. Despite performing “arduous” tasks, Pallette dismissed the myth of nurses as merely maids in white uniforms. Nursing school required a “high degree of intelligence,” as well as good study habits to learn the material and pass the State Board’s nursing exam. Setting the expectations high, Pallette warned, “Our graduates never fail in these. Unless you are a good student, do not undertake this work.”

But physical health, good moral character, and intelligence were not enough. Pallette knew that nurses needed good judgment. They needed to know how to accurately apply their knowledge, “doing the right thing at the right time.” To Pallette, nursing was a science, an art, and above all, a profession. In fact, he considered nursing “the highest of all professions open to women,” and encouraged nurses to develop a professional demeanor, although he also warned them to “not be too everlastingly professional.”

To succeed in a Daughters of Charity hospital, nurses needed to be willing to work hard while still maintaining an attitude of compassion towards their patients.

Overall, the nurses’ training school folded nicely into the sisters’ established system, and the students provided essential services with relatively little cost. With the exception of religious exercises, nursing students worked on the same basis as sisters—exchanging labor for training and material support. The school also functioned as a recruiting tool, as some students chose to join the community. Even for those who did not see the sisterhood as their vocation, the school’s graduates formed a labor pool of nurses thoroughly inculcated in the methods and practices of the Daughters of Charity. And as more sisters became registered nurses themselves, they gained both the secular authority to supervise a modern scientific institution while continuing to maintain their religious identity. As with buying x-ray machines and contracting with railroad health programs, nursing schools operated as a strategy to maximize the community’s autonomy and continue its mission to the sick poor.

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467 Pallette, “Address of the President of the Staff at the Opening of School,” 28.
468 Ibid.
469 Ibid., 29.
Conclusion

Hospital history in the twentieth century has been a tale of increased government involvement, a growing demand for new technology, and the selective expansion of access to care. Medicare, Medicaid, third-party insurance, and health management organizations have shaped the ways that hospitals received payment for their services, while access to new technologies, the recruitment of physicians, and the implementation of government regulations have affected its availability. These developments resulted in the need for substantial amounts of capital to build larger physical plants, to buy state-of-the-art equipment, and to attract qualified physicians and their patients. Meanwhile, the delivery of charity services had to be pragmatically tempered with market realities, even by Catholic sisters committed to caring for the poor.470 While these trends were certainly accentuated (and accelerated) in the last century, their roots extend into nineteenth-century Los Angeles. The Daughters of Charity adjusted, amended, and adapted their business practices to changing economic and political conditions as the city grew from a sleepy Mexican pueblo to a sprawling American metropolis. Service remained key in the sisters’ approach to their hospital’s development, and they managed to maintain the institution’s vitality without relinquishing their commitment to care for the sick poor.

When the Daughters of Charity arrived in 1856, Los Angeles had no institutionalized health services. Doctors like Richard Den, Thomas Foster, and John S. Griffin diagnosed and treated patients in their homes, and boardinghouse owners like Robert Owens sheltered and nursed the indigent sick.471 The arrival of an experienced nurse like Sister Ann Gillen, coupled with the international reputation of the Daughters for quality and efficient hospital care, provided an opportunity

470 For a discussion of Catholic adaptations to the twentieth-century hospital market, see Wall, American Catholic Hospitals.

471 “Minutes, 24 March 1857,” Book 2 (8 November 1855–16 January 1861), 85–88, Historical Board Minutes, Box 1, LACBS, Los Angeles.
for Los Angeles county officials to introduce a more formal system of public health services. While the sisters’ hospital (officially called the Los Angeles Infirmary) was privately owned and operated, the county provided most of its funding during the 1860s and 1870s. Government funding facilitated the sisters’ efforts to extend nursing care to the sick poor, and gave the Daughters of Charity more financial resources to devote towards charity work than they would have otherwise had.

In 1858, government intervention jumpstarted the development of hospital care in Los Angeles, but it was the experience, training, and management of the Daughters of Charity that ensured its continuation. As city officials discovered during the 1877 smallpox epidemic, few residents trusted government-run hospitals. Politicians soon realized that before infected individuals could be induced to enter, they needed the Daughters to lend their “angelic reputations” to the city-owned pest house. Likewise, the sisters’ efficiency at the Los Angeles Infirmary bolstered the county’s reputation for quality social services. The partnership between the Daughters and the Los Angeles County Board of Supervisors lasted for two decades because both parties benefitted. The county streamlined its charity operations, and the improvement in health services boosted the region’s reputation, making it more attractive for business investment. The Daughters of Charity shaped the delivery of public health services for thousands of individuals, integrating the sisters’ philosophy of compassion and respect for poor persons regardless of race or creed.

Because they operated a “private project in the public interest,” the sisters were thrust into the economic and political turmoil that accompanied the city’s urban development. Sick and weary migrants trudged to Los Angeles from war-torn southern states and the flooded fields of northern California. Combined with the costs of the 1869 smallpox epidemic, an increased demand for charitable assistance for the indigent sick started to empty government coffers. As we see with Medicare and Medicaid today, when costs rise faster than revenue is generated, government reduces its reimbursements to healthcare providers, expecting them to either do more with less or make up the difference from other sources. The county supervisors pressured the Daughters of Charity to reduce rates by 25 percent in 1871, and since these funds were never restored to previous levels, it became difficult for the hospital to cover basic costs and opened the sisters up to charges of providing substandard care.

Economic exigencies occurred at the same time as political changes within the medical profession. As city boosters attempted to capitalize on southern California’s healthy climate, doctors and health seekers migrated to the region. The members of the newly established Los Angeles County Medical Association sought to clamp down on “irregular practitioners,” and they embraced scientific medicine as a vehicle to enhance physicians’ economic, cultural, and political power. In their eyes, a health-oriented economy required scientific medical institutions, and assumptions about gender, subservience, and lack of professional status played into the hands of politicians whose vision of a “modern” city did not include the small hospital managed by women in blue habits and white cornettes.

While the complications of government-funded care dominated the hospital’s second decade, adapting to the private medical marketplace remained a major concern for the rest of the nineteenth century. After the dissolution of their partnership with the county in 1878, the Daughters of Charity reinvigorated the Los Angeles Infirmary by investing in a new physical plant, including specialized medical spaces such as an operating room. The 1884 hospital also acted as a transitional space, blending the best of the sisters’ traditional practices with the best of scientific medicine. The Daughters continued to provide care for consumptives and others with chronic conditions, but they also reached out to sailors and railroad corporations to expand their patient base in the 1890s and early 1900s. They raised chicken and cattle to provide for their patients and to give food to the hungry, yet also took advantage of the oil deposits beneath

472 Ryan, Civic Wars, 104.
their feet, requiring precautions that petroleum development would occur in an aesthetically pleasing and environmentally friendly manner. The Daughters of Charity sought to retain their historic position as leaders in hospital care in Los Angeles, building facilities to attract doctors and their private patients and opening a nursing school. The school, in particular, allowed them to inculcate generations of young women with the sisters’ holistic approach to nursing, treating diseases of the body while remaining concerned for the soul.

Despite the growing importance of technology and an increasing reliance on private patients, the Daughters of Charity remained committed to their religious charge to care for the sick poor. At the turn of the twentieth century, 44 percent of the hospital’s patients worked for a railroad, many of whom would be considered among the working poor.

In addition, the Daughters opened an outpatient clinic for minor surgical cases, extended free or subsidized care for impoverished patients, and visited the poor living in surrounding neighborhoods.

Throughout the late nineteenth and early twentieth centuries, the Daughters of Charity balanced innovative business practices with continued care for the sick poor. The sisters did acknowledge the growing importance of technology in hospital care by acquiring an x-ray machine for their new hospital building in 1902, and it appears the Los Angeles Infirmary was the first privately owned hospital in the city to possess one. They also kept pace with efforts to improve efficiency and patient care. Sister Alice Ratery operated an in-house pharmacy in 1900, and by 1920, the sisters had instituted a record management system and introduced standardized laboratory tests. So, by the time their newest facility opened in 1927, the Daughters of Charity had fully embraced the image of their hospital as a scientific institution that incorporated a religious mission.

“A MONUMENT TO CHRISTIAN CHARITY”: THE NEW ST. VINCENT’S HOSPITAL, 1927

At 4:30 p.m. on 22 January 1927, a short circuit sparked a fire in the attic of the 1902 Annex of Sisters’ Hospital. The rotunda was quickly ablaze, catching the attention of a policeman outside who called the fire department. Although sick in bed with pneumonia, Sister Mary Ann Keating ordered that all 125 patients be removed from the building. Thanks to the help of neighbors, the staff quickly accomplished this task. Most patients were placed on the lawn within fifteen minutes, and mothers and infants in the maternity wards were sent to the Nurses’ Home on another part of the property. Josephine Tracy, a long-time employee of the hospital, refused to desert her post as telephone operator, taking an “avalanche of telephone calls through her switchboard until all outside connections burned away.”

The blaze destroyed the sixth floor, dome, and rotunda, and caused an estimated $35,000 in damage. But, Sister Mary Ann was grateful that there had been no more damage. She commented, “if this had ever happened at night, I doubt if we would be here to-day.”

Although the fire was potentially disastrous for the hospital’s economic

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future, the Daughters of Charity were already in the midst of construction on a new facility. Unfortunately, the hospital would not be ready for several months. Understanding their situation, the city building inspector gave the sisters a permit to remain on the second and third floors until their new facility opened—even though the 1902 building did not comply with 1927 building codes. The reduced-bed capacity placed an additional financial strain on the sisters, reducing needed income and potentially making it more difficult to sell the property to pay for additional construction.475 Nevertheless, the Daughters continued with their construction efforts, borrowing money and conducting the hospital’s first public fundraising campaign. After seventy years of the sisters’ service, Bishop John J. Cantwell hoped that “this hospital [may] stand through the years a monument to Christian Charity, an emblem of the consecrated lives of the Daughters of Charity, and an inspiration to the citizens of this community.”476

Los Angeles was certainly a different place than when the Daughters of Charity arrived at San Pedro in 1856. In 1850, the population stood at 1,610. By 1920, the population was 577,000 and ten years later it had reached 1.24 million. In 1850, the economy relied primarily on agriculture, cattle, and coastal trade. By 1929, the Los Angeles basin became a major oil producer, the second largest producer of automobile tires, the capital of the aviation industry in the United States, and the center of the motion picture industry. In the 1920s, the city added eighty square miles and annexed forty-five neighboring communities. Protestants dominated amongst the 326,000 church-goers in 1926. And, although Caucasians held the majority, the growth in Mexican, Japanese, and African American populations gave Los Angeles the distinction of having the second-largest percentage of nonwhites in any major city in the United States.477

The city’s tremendous growth placed a strain on hospital facilities and in 1923, the Los Angeles Times claimed, “Every day for lack of space [area hospitals] refuse nearly as many patients as they have beds.”478 Hospitals hastened to adapt and by 1925, twelve hospitals had embarked on building projects to increase capacity from 3,700 to 10,700 beds. With the exception of County Hospital which was in the midst of a $700,000 construction project, religious hospitals formed the majority of the institutions involved in the building boom. California Lutheran Hospital, Methodist Hospital, Good Samaritan, Kaspare Cohn, and St. Vincent’s were all building new facilities, with costs estimated from $500,000 to $1.5 million.479 The massive building campaign represents the growing demand for hospital facilities, perceived economic opportunities by hospital administrators, and the competition between religious hospitals to attract private patients. The Daughters of Charity engaged in this campaign to ensure that they could retain a competitive edge in the city’s hospital market, bringing in the necessary funds to subsidize their ongoing care of the indigent sick. While the Sunset Hospital represented a transition between the traditional and modern, the new St. Vincent’s Hospital thoroughly embraced modernity as an urban scientific medical institution. Located on Alvarado Street and Oceanview Avenue, the hospital sat atop a hill overlooking the city. Gone were the chicken coops, the cow

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475 “Flames Badly Damage St. Vincent’s Hospital: Heroism of Sisters, Nurses, and Fireman Avert Loss of Life.”


478 “Hospital Facilities of City Are Inadequate,” Los Angeles Times, 23 September 1923.

pasture, and the oil wells. They were replaced by a central kitchen, hydrotherapy treatment center, and radiograph, x-ray, and bacteriology labs. For the first time, the operating room had a separate observer’s area, so nursing students could view procedures without entering the aseptic space. Opened on 25 November 1927, the design eliminated large rectangular wards, and featured four stories almost entirely devoted to private rooms. However, each floor had some four-bed wards, a semi-private space for less wealthy patients. Charity patients may have also been housed in some of these wards, but the sisters did not specifically designate any space as the “charity ward,” thus providing poor persons with similar accommodations as paying patients. The maternity wards occupied the sixth floor, and the operating rooms and labs occupied the seventh. Although no longer surrounded by trees and fields, the architects still sought to provide some association with nature in the hospital, incorporating a solarium on each floor and a roof-top garden. The new St. Vincent’s Hospital epitomized the modern facility of the 1920s and 1930s.

With a final cost of two million dollars, the sisters wanted to assure the building’s longevity. Architects John C. Austin and Frederick M. Ashley designed the building with future technological improvements in mind. Beneath the surgery floor they installed a “pipe loft” that “makes it possible to install any new sanitary, electrical or ventilating appliances that may be discovered or invented, and found to be desirable, without affecting or disturbing the structural elements of the building.” In addition, the architects sought to protect the building from disaster, whether natural or man-made, and thoroughly fireproofed it, while designing the structure with reinforced concrete to prevent potential earthquake damage. After the Santa Barbara quake in 1925, St. Francis Hospital suffered so much damage that it had to be entirely rebuilt, even though it had only been open for five months. Meanwhile, the solid construction of the sisters’ orphanage survived with relatively little damage. After viewing the wreckage, Sister Mary Ann Keating decided, “After all it is better to put up a good building even if the first cost is more, for if they had not, now they would have none at all.” She insisted on so much rebar in the reinforced concrete that workers had tremendous difficulty tearing down the building to replace the hospital in 1975. The wrecking balls literally bounced off.

The new St. Vincent’s Hospital evoked images of modernity, both from within and without. Besides the mass of private rooms, the maternity ward, and the laboratory space, St. Vincent’s also attracted a well-qualified, professional staff. Several physicians had been faculty at either the University of Southern California’s Medical College or the Medical Department at what would become the University of California at Los Angeles. Ernest A. Bryant, a surgeon at Sisters’ Hospital, also held the position of Chief Surgeon for several of Los Angeles’ local rail companies, including the Pacific Electric, Los Angeles Railroad, Los Angeles Interurban Railroad, San Bernardino Valley Railroad, the Santa Ana and Orange Railroad, as well as the Pacific Light and Power Company and Los Angeles Gas Company. In the early days, the sisters did all the nursing, but by 1925, twenty-five sisters worked at the hospital, as well as sixty-five nurses. Sister Mary Ann Keating, the hospital administrator from 1904 to 1941, was herself a registered nurse. Sisters supervised the operating room, pharmacy, laboratory, and patient floors. By 1925 all of these sisters were registered nurses or had other appropriate professional designations. Patients were attended either by graduate or student nurses, and St. Vincent’s Hospital emphasized its professionalism by maintaining a staff whose credentials could not be questioned.

Yet, the Daughters of Charity did not embrace modernity at the cost of tradition. The sisters maintained their commitment to charity, allowing those in difficult financial straits to pay only part of their bill, if they were able to pay at all. Fundraising campaign materials stated that 21 2/3 percent of all patients treated at the hospital in 1925 were charity patients. Of these, 194 people paid nothing for their care, and 246 paid for only part of their care. Fundraisers asserted that the hospital averaged fifteen charity patients per day, the value of which equaled $21,191.00.

The Daughters of Charity also maintained their connection with the california families that supported their institutions in the nineteenth century. María de los Reyes Domínguez de Francis donated $150,000 for the chapel and a home for the sisters. She also donated a 1927 Cadillac for the sisters to raffle off in an effort to raise additional funds. Joseph Wolfskill, his wife Elena Pedorena de Wolfskill,

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484 Mary Ann Keating, D.C., to Eugenia Faley, D.C., 4 July 1925, Office of the President/CEO Records, 1856-1997, SVMCHC HC002, Box 35, Folder 15, SVMCHC, Los Angeles.
487 Advertisement for Fundraising Campaign, St. Vincent’s Hospital,” c. 1926, Office of the President/CEO Records, 1856-1997, SVMCHC HC002, Box 35, Folder 12, SVMCHC, Los Angeles.
488 “Mrs. Francis Gives $150,000 to Saint Vincent’s Hospital. 11 February 1927,” Ibid., Folder 9.
and his sister Francesca Wolfskill de Shepherd (who sold the sisters property for an
orphanage in Boyle Heights in the 1880s), contributed to the hospital fund, as did
John Mott, who married into the Sepulveda family, and two of Ygancio del Valle’s
dughters, Josefa del Valle Forster and Ysabel del Valle Crum. The McGarrys,
Sullivans, Schumachers, and Murphys continued their support of the sisters, just
as they had during the orphans’ fairs thirty-five years before. As evidenced by
multiple generations of support, the Daughters had built a place for themselves
within the social fabric of the city of Los Angeles. Although the urban landscape
had changed from a dusty pueblo to a sprawling metropolis, the Daughters of
Charity continued to stake their claim as an essential part of the support network
for “suffering humanity” as they built a new monument to charity atop the hill.

APPENDIX A:

TABLES

Data for tables 2.1-2.3 compiled from Book 2 (8 November 1855-16 January
1861), Box 1, Historical Board Minutes, Executive Office of the Los Angeles
County Board of Supervisors, Los Angeles. Tables created by the author.

<table>
<thead>
<tr>
<th>Date</th>
<th>Room and Board Cost</th>
<th>Physician Cost</th>
<th>Pharmacy Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1855</td>
<td>$710.12</td>
<td>$865.72</td>
<td>$6.75</td>
<td>$1582.62</td>
</tr>
<tr>
<td>February 1856</td>
<td>$755.93</td>
<td>$603.25</td>
<td>$193.00</td>
<td>$1552.18</td>
</tr>
<tr>
<td>June 1856</td>
<td>$472.75</td>
<td>$592.25</td>
<td>$0</td>
<td>$1065.00</td>
</tr>
<tr>
<td>August 1856</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>November 1856</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>March 1857</td>
<td>$980.66</td>
<td>$544.75</td>
<td>$11.00</td>
<td>$1536.41</td>
</tr>
<tr>
<td>June 1857</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>August 1857</td>
<td>$0</td>
<td>$100.00</td>
<td>$0</td>
<td>$100.00</td>
</tr>
<tr>
<td>November 1857</td>
<td>$0</td>
<td>$385.00</td>
<td>$0</td>
<td>$385.00</td>
</tr>
<tr>
<td>February 1858</td>
<td>$240.50</td>
<td>$410.00</td>
<td>$60.50</td>
<td>$711.00</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$3159.96</td>
<td>$3500.97</td>
<td>$271.25</td>
<td>$6932.21</td>
</tr>
<tr>
<td>Average Cost (10 quarters)</td>
<td>$315.99</td>
<td>$350.09</td>
<td>$27.12</td>
<td>$693.22</td>
</tr>
</tbody>
</table>

Note: Pharmacy costs are underrepresented since sometimes physicians and care providers
paid for the medicine and were reimbursed, not the pharmacist. Payments were not
recorded from the Hospital fund in August 1856, November 1856, and June 1857.

487 “St. Vincent’s Hospital Benefactors’ Plaque,” 1927, SVMCHC, Los Angeles.
Table 2.2  Los Angeles County Expenses for the Indigent Sick, August 1858-November 1860 (After Sisters’ Hospital)

<table>
<thead>
<tr>
<th>Date</th>
<th>Sisters’ Costs</th>
<th>Physician Cost</th>
<th>Pharmacy Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1858</td>
<td>349.00</td>
<td>80.00</td>
<td>125.75</td>
<td>554.75</td>
</tr>
<tr>
<td>November 1858</td>
<td>868.00</td>
<td>80.75</td>
<td>148.25</td>
<td>1097.00</td>
</tr>
<tr>
<td>February 1859</td>
<td>905.00</td>
<td>0</td>
<td>421.00</td>
<td>1326.00</td>
</tr>
<tr>
<td>May 1859</td>
<td>1029.00</td>
<td>0</td>
<td>250.00</td>
<td>1279.00</td>
</tr>
<tr>
<td>August 1859</td>
<td>732.00</td>
<td>0</td>
<td>44.25</td>
<td>776.25</td>
</tr>
<tr>
<td>December 1859</td>
<td>706.00</td>
<td>0</td>
<td>184.50</td>
<td>890.50</td>
</tr>
<tr>
<td>February 1860</td>
<td>695.00</td>
<td>0</td>
<td>0</td>
<td>695.00</td>
</tr>
<tr>
<td>May 1860</td>
<td>807.00</td>
<td>0</td>
<td>0</td>
<td>807.00</td>
</tr>
<tr>
<td>August 1860</td>
<td>368.00</td>
<td>0</td>
<td>164.50</td>
<td>532.50</td>
</tr>
<tr>
<td>November 1860</td>
<td>779.00</td>
<td>0</td>
<td>29.25</td>
<td>808.25</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$7238.00</td>
<td>$160.75</td>
<td>$1367.50</td>
<td>$8766.25</td>
</tr>
<tr>
<td>Average Cost</td>
<td>$723.80</td>
<td>$16.07</td>
<td>$136.75</td>
<td>$876.62</td>
</tr>
</tbody>
</table>

Note: In May 1859, the board instituted a rotation system of visiting physicians for the county hospital. This was likely an unpaid position, although the board continued to pay Dr. John S. Griffin for treating sick prisoners at the county jail. These payments were drawn out of the jail fund or current expenses fund, not the hospital fund. See Minutes, 4 May 1859. Minutes, 21 November 1859-9 Nov 1863, Book 2 (8 November 1855-16 Jan 1861) Historical Board Minutes Box 1, LACBS.

Table 2.3  Summary of Los Angeles County Hospital Costs, 1855-1860

| Board and nursing costs Nov 1855-May 1858 | $3159.26 |
| Board and nursing costs May 1858-Nov 1860 | $7238.00 |
| Percentage Growth 1855 to 1860 | 129% |

Data for tables 3.1 and 3.2 represent a random sample of 2154 patient records calculated with a four percent margin of error (476 patient records). See Appendix B for sampling method. Hospital Admissions Book, 1872-1896. St. Vincent Medical Center Historical Conservancy, Los Angeles. Tables created by the author.
### Table 5.2 Conditions Treated at Sisters’ Hospital, 1879-1907

<table>
<thead>
<tr>
<th>Condition</th>
<th>1879–1886</th>
<th>1889–1900</th>
<th>1901–1907</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Disorder</td>
<td>11</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Gastrointestinal Disorder (Vomiting, Diarrhea, Indigestion, etc.)</td>
<td>2</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Infection</td>
<td>159</td>
<td>151</td>
<td>158</td>
</tr>
<tr>
<td>Consumption or Tuberculosis</td>
<td>63</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>Typhoid Fever</td>
<td>3</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>Malaria</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>La Grippe</td>
<td></td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Non-specific Fever</td>
<td>81</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Metabolic Disorder (Diabetes, Gout)</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Musculoskeletal Disorder</td>
<td>24</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Rheumatism</td>
<td>22</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Neurolologic Disorder (Dementia, Paralysis, St. Vitus Dance)</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Old Age or Debility</td>
<td>11</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Psychological Condition (Insanity, Nervous Prostration)</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Reproductive System</td>
<td>9</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Obstetrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse (Alcoholism, Morphine Addiction)</td>
<td>2</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Surgery&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>45</td>
<td>78</td>
<td>116</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>5</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Amputations</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Cuts, Scrapes, or Bruises</td>
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<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Gun Shot Wounds</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Tumors (Benign or Cancerous)</td>
<td>10</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Liver Complaints</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bright’s Disease</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis Unrecorded</td>
<td>147</td>
<td>215</td>
<td>176</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>446</td>
<td>569</td>
<td>579</td>
</tr>
</tbody>
</table>

* Surgery: These figures are inexact because surgery is a treatment, not a diagnosis. Some of the conditions included in other categories may have resulted in surgery, such as appendicitis. However, the records for 1889–1900 included a number of unspecified “operations” that could not be categorized elsewhere. In addition, changes in diagnosis and record-keeping practices must be taken into account when analyzing the overall data. For example, patients admitted with a non-specific fever in 1880 may have been diagnosed with a more specific ailment in 1900. In many cases, trauma was largely unspecified. Patients were admitted with conditions like “injured arm,” “sore knee,” or “wounded forehead.” Keeping case records did not become standard practice until the 1920s, so approximately one-third of patients did not have their diagnoses recorded at all (33 percent for 1878–1886, 38 percent for 1889–1900, and 31 percent for 1901–1907). The data reflects larger patterns, although admittedly, it is not entirely conclusive.

### Table 5.3 Southern Pacific Railroad Patients by Disease Type, 1889-1907

<table>
<thead>
<tr>
<th>Condition</th>
<th>1889–1900</th>
<th>1901–1907</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Disorder</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal Disorder (Vomiting, Diarrhea, Indigestion, etc.)</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Infection</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>Consumption or Tuberculosis</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Typhoid Fever</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Malaria</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>La Grippe</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Unspecified Fever</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal Disorder</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Rheumatism</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Neurolologic Disorder (apoplexy, sciatica)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Debility</td>
<td>1</td>
<td></td>
</tr>
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<td>Psychological Condition (insanity)</td>
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<td><strong>All Patients in Sisters’ Hospital</strong></td>
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<sup>a</sup> Surgery: These figures are inexact because surgery is a treatment, not a diagnosis. Some of the conditions included in other categories may have resulted in surgery, such as appendicitis. However, the records for 1889–1900 included a number of unspecified “operations” that could not be categorized elsewhere. In addition, changes in diagnosis and record-keeping practices must be taken into account when analyzing the overall data. For example, patients admitted with a non-specific fever in 1880 may have been diagnosed with a more specific ailment in 1900. In many cases, trauma was largely unspecified. Patients were admitted with conditions like “injured arm,” “sore knee,” or “wounded forehead.” Keeping case records did not become standard practice until the 1920s, so approximately one-third of patients did not have their diagnoses recorded at all (33 percent for 1878–1886, 38 percent for 1889–1900, and 31 percent for 1901–1907). The data reflects larger patterns, although admittedly, it is not entirely conclusive.
### Table 5.4  Age for All Patients at Sisters’ Hospital, 1872-1907

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<tr>
<th>Age Group</th>
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<th>1889-1900</th>
<th>1901-1907</th>
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<td>Child (4-12 years)</td>
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### Table 5.5  Southern Pacific Railroad Patients by Age, 1889-1907

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### Table 5.6  All Patients by National Origin, 1872-1907

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### Table 5.7  U.S.-Born Patients by State of Origin, 1872-1907

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### Table 5.8  Southern Pacific Railroad Patients by National Origin, 1889-1907

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<td>Japan</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Mexico</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>Norway</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Scotland</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>USA</td>
<td>43</td>
<td>50</td>
</tr>
<tr>
<td>Wales</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>West Indies</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>120</td>
</tr>
</tbody>
</table>
Table 5.9  All Patients by Place of Residence, 1872-1907

<table>
<thead>
<tr>
<th>Last City of Residence</th>
<th>1872-1878</th>
<th>1879-1886</th>
<th>1889-1900</th>
<th>1901-1907</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>225</td>
<td>202</td>
<td>280</td>
<td>224</td>
</tr>
<tr>
<td>Southern California</td>
<td>38</td>
<td>55</td>
<td>110</td>
<td>190</td>
</tr>
<tr>
<td>Northern California</td>
<td>18</td>
<td>24</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Arizona, Texas, or New Mexico</td>
<td>1</td>
<td>32</td>
<td>24</td>
<td>34</td>
</tr>
<tr>
<td>Elsewhere in the United States</td>
<td>10</td>
<td>33</td>
<td>37</td>
<td>29</td>
</tr>
<tr>
<td>Elsewhere in the World (includes sailors)</td>
<td>3</td>
<td>5</td>
<td>9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>25&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unknown</td>
<td>181</td>
<td>95</td>
<td>87</td>
<td>60</td>
</tr>
<tr>
<td>Grand Total</td>
<td>476</td>
<td>446</td>
<td>569</td>
<td>579</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data includes seven sailors for 1889-1900, and thirteen sailors from 1901-1907, who came to the hospital directly from their ships.

Table 5.10  Southern Pacific Railroad Patients by Place of Residence, 1889-1907

<table>
<thead>
<tr>
<th>Last City of Residence</th>
<th>1889-1900</th>
<th>1901-1907</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>71</td>
<td>44</td>
</tr>
<tr>
<td>Southern California</td>
<td>24</td>
<td>45</td>
</tr>
<tr>
<td>Northern California</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Arizona, Texas, or New Mexico</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Elsewhere in the United States</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Elsewhere in the World</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>127</td>
</tr>
</tbody>
</table>

Table 5.11  Patients by Gender at Sisters’ Hospital, 1872-1907

<table>
<thead>
<tr>
<th>Gender</th>
<th>1872-1878</th>
<th>1879-1886</th>
<th>1889-1900</th>
<th>1901-1907</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>56</td>
<td>77</td>
<td>165</td>
<td>106</td>
</tr>
<tr>
<td>Male</td>
<td>419</td>
<td>369</td>
<td>402</td>
<td>471</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>476</td>
<td>446</td>
<td>569</td>
<td>579</td>
</tr>
</tbody>
</table>

The data for tables 5.12 and 5.13 was compiled from “Financial and Statistical Statements, 1913-1945.” Box 35, Folder 3, Office of President Collection. St. Vincent Medical Center Historical Conservancy, Los Angeles. Tables created by the author.

Table 5.12  Charity for Patients at St. Vincent’s Hospital, 1913-1930<sup>a</sup>

<table>
<thead>
<tr>
<th>Year</th>
<th>Free Patients</th>
<th>Part Pay Patients</th>
<th>Pay Patients</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913</td>
<td>112</td>
<td>145</td>
<td>1744</td>
<td>2001</td>
</tr>
<tr>
<td>1914</td>
<td>92</td>
<td>225</td>
<td>1643</td>
<td>1960</td>
</tr>
<tr>
<td>1915</td>
<td>94</td>
<td>227</td>
<td>1293</td>
<td>1614</td>
</tr>
<tr>
<td>1917</td>
<td>158</td>
<td>2102</td>
<td></td>
<td>2260</td>
</tr>
<tr>
<td>1918</td>
<td>207</td>
<td>1975</td>
<td>1793</td>
<td>2182</td>
</tr>
<tr>
<td>1919</td>
<td>202</td>
<td>1975</td>
<td>1793</td>
<td>1995</td>
</tr>
<tr>
<td>1920</td>
<td>117</td>
<td>2072</td>
<td>2189</td>
<td></td>
</tr>
<tr>
<td>1921</td>
<td>102</td>
<td>2109</td>
<td>2211</td>
<td></td>
</tr>
<tr>
<td>1922</td>
<td>156</td>
<td>2233</td>
<td>2412</td>
<td></td>
</tr>
<tr>
<td>1923</td>
<td>182</td>
<td>2165</td>
<td>2373</td>
<td></td>
</tr>
<tr>
<td>1924</td>
<td>150</td>
<td>2310</td>
<td>2483</td>
<td></td>
</tr>
<tr>
<td>1926</td>
<td>132</td>
<td>2460</td>
<td>2619</td>
<td></td>
</tr>
<tr>
<td>1927</td>
<td>64</td>
<td>351</td>
<td>1985</td>
<td>2400</td>
</tr>
<tr>
<td>1928</td>
<td>159</td>
<td>1307</td>
<td>2570</td>
<td>4036</td>
</tr>
<tr>
<td>1929</td>
<td>187</td>
<td>1446</td>
<td>2887</td>
<td>4520</td>
</tr>
<tr>
<td>1930</td>
<td>220</td>
<td>115</td>
<td>4922</td>
<td>5257</td>
</tr>
</tbody>
</table>
Table 5.13  Charity Work for the Poor at St. Vincent’s Hospital, 1913-1930

<table>
<thead>
<tr>
<th>Year</th>
<th>Families Visited and Relieved</th>
<th>Poor Relieved at the House</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913</td>
<td>224</td>
<td>550</td>
</tr>
<tr>
<td>1914</td>
<td></td>
<td>600</td>
</tr>
<tr>
<td>1915</td>
<td>55</td>
<td>750</td>
</tr>
<tr>
<td>1917</td>
<td>75</td>
<td>1380</td>
</tr>
<tr>
<td>1918</td>
<td>75</td>
<td>1450</td>
</tr>
<tr>
<td>1919</td>
<td>80</td>
<td>1525</td>
</tr>
<tr>
<td>1920</td>
<td>86</td>
<td>1535</td>
</tr>
<tr>
<td>1921</td>
<td>95</td>
<td>1520</td>
</tr>
<tr>
<td>1923</td>
<td>25</td>
<td>2390</td>
</tr>
<tr>
<td>1924</td>
<td>50</td>
<td>1095</td>
</tr>
<tr>
<td>1926</td>
<td>106</td>
<td>1635</td>
</tr>
<tr>
<td>1927</td>
<td>96</td>
<td>1724</td>
</tr>
<tr>
<td>1928</td>
<td></td>
<td>2190</td>
</tr>
<tr>
<td>1929</td>
<td>39</td>
<td>1095</td>
</tr>
<tr>
<td>1930</td>
<td>75</td>
<td>2920</td>
</tr>
</tbody>
</table>

*The annual reports for 1916 and 1925 are missing. The data for charity work at the hospital in 1922 was not recorded on the report (Table 7.2).

APPENDIX B:

HOSPITAL DATA

I. SAMPLING METHOD

The earliest admissions books housed at the St. Vincent Medical Center Historical Conservancy (SVMCHC) cover the years 1872 to 1907. I viewed the archival records at SVMCHC and entered the data into an Excel workbook or database. To streamline data collection and minimize the disclosure of “protected health information” (PHI), as defined by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I collected a random sample of patient records from each admission book. I also separated the records into smaller sample sizes because the hospital experienced significant changes during this time period. The Los Angeles Infirmary received county funding to support charity patients until 1878, so I needed to compare conditions in the hospital before and after that date. My first sample was from 1872-1878. Because patient admissions were not recorded in the book for 1887 and 1888, the second sample was from 1879-1886, the third was 1889-1900, and the final sample covered 1901-1907.


To determine the sample size, I used the following formula (see Scheaffer, et al., 99.):

\[
n = \frac{Npq}{D^2} \quad q = 1 - p \
\]

For example, the 1901-1907 admissions book has 8488 patient records. Therefore, the population size (N) is 8488. As a conservative estimate, I chose to select a 50 percent proportion and 4 percent margin of error. The estimated proportion and margin of error remain consistent throughout the sampling of all admissions books, although the population size varies.

Random Sample for years 1901-1907:
- Estimated Proportion (p) 50%
- Population Size (N) 8488
- Margin of Error (B) 4%
- Sample Size (n) 582.20

Sample Size as a Percentage 0.068591
As with any historical document, data collection reflects the priorities of admissions officers at the time the record was created. Collection processes may have varied because of changing state reporting requirements, new professional standards, business needs, or the training of the admitting officer. The original patient record may contain date of admission, name, age, place of birth, address and last city of residence, occupation, religion, patient type, diagnosis, attending physician, and date of discharge and/or death. However, all fields were not completed for each patient in every time period, and I had to assess the effects of these inconsistencies during my analysis after data collection was complete. If the field was left blank in the admissions book, I left it blank in the database. I did not transcribe the entire patient record into my database, but followed the data collection plan listed below.

II. DATA COLLECTION PLAN

Patient Record Number: Patient record numbers provide a common denominator between all columns in the database from which to conduct an analysis. When combined with the year, they provide an avenue to verify the data against the original source and to prevent errors. However, patient record numbers were masked by assigning a code that is “not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual,” and the key for re-identification will be kept in a separate file as allowed in the Code of Federal Regulations [45 CFR 164.415 (c) (1) (2)]. Masking the patient record numbers limits the use of PHI.

Year: Year is important in determining change in the other categories over time. Data was analyzed by year. Specific admission and discharge dates (i.e. month and day) were not necessary for the analysis.

Gender: As hospital care became more acceptable for all classes at the end of the nineteenth century, the gender distribution among patients changed. In the period under study, admitting officers did not identify a patient’s gender in a separate column in the admissions books, but gender can be extrapolated from patient names. Patient names were not recorded in the database, but were converted to accepted abbreviations for gender: m = male, f = female.

Age: Ages remain important in determining who used the hospital and why. With this data, I should be able to track the average patient age as it changed over time, and thus illustrate the changing character of the hospital’s services. Specific ages were recorded in order to calculate the average patient age. Patients were also placed in age groups to determine the percentages of children, adults, and elderly treated at the hospital. Age groups are as follows: Newborn (0-1 year), Toddler (1-3), Child (3-12), Adolescent (13-19), young adult (20-29), adult (30-49), and middle aged (50-69). The elderly were divided into two categories, (70-89) and (90 and above).

Place of Birth: Place of birth is important in determining the hospital’s relationship with the immigrant communities in Los Angeles. Place of birth was recorded by state or country in the database.

Last City of Residence: Last city of residence is necessary to determine the percentage of patients that were Los Angeles County residents. In the 1870s, the County Board of Supervisors tried to limit its payments for the medical expenses of non-residents, so the issue of residency became a political issue and also affected the hospital’s bottom line. “Last City of Residence” is also useful when attempting to track migration to Los Angeles from other locations within the United States. In the late nineteenth and early twentieth centuries, the city attracted many “health-seekers,” migrants from the Midwest and overseas who traveled to Southern California in hopes of improving their health. Some of these individuals arrived very sick, and went directly to the hospital. “Last City of Residence” may be useful in determining the extent to which patients in this situation were treated at the Los Angeles Infirmary.

Patient Type: The admissions officer assigned codes to patients at the time of admission. Codes categorized patient according to room type and payment type.

<table>
<thead>
<tr>
<th>Room Type:</th>
<th>Ward</th>
<th>Private Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Type:</td>
<td>Ward Patient (paying)</td>
<td>Private Patient (paying)</td>
</tr>
<tr>
<td>Charity Patient (non-paying)</td>
<td>Southern Pacific Employee (contract patient)</td>
<td></td>
</tr>
<tr>
<td>Santa Fe Railroad (contract)</td>
<td>Pacific Electric (contract)</td>
<td></td>
</tr>
<tr>
<td>Sailor/U.S. Marine (contract)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the case of railroad workers and sailors, these codes identify a patient’s employer (e.g. Southern Pacific, Santa Fe). However, neither names nor specific admission dates were collected, thus making it difficult to identify an individual in combination with other records.

Occupation: Occupation is useful in determining a patient’s class status. In evaluating the sisters’ continuing mission to the poor, it is important to determine (as best as is possible) the class status of those using the hospital. Since charity cases were no longer regularly identified after 1890, occupation becomes an important clue in tracking the hospital’s continuing relationship with the working-class community. Secondly, occupation will assist in determining the percentage of railroad workers admitted to the hospital in the 1890s.
Religion: Religion may have been a significant factor in a patient’s choice of hospitals. The sisters offered hospital care to all regardless of religious affiliation, but it is important to quantify the extent to which Catholics, Protestants, Jews, and others used the facility.

Diagnosis: The admissions officer, or perhaps the examining physician, recorded a brief diagnosis in the admissions book. These include things like “injured arm,” “tuberculosis,” “fever,” “tonsillitis,” and “obstetrical.” The diagnosis is helpful in determining the types of treatments available at the hospital over time, from convalescent care of chronic diseases to acute care and surgical procedures.

The above descriptions represent the “minimum necessary” data required to conduct my research. The study was designed to provide adequate precautions against the disclosure of individual patient identities, but still allowed me to accomplish my research goals. Excluding patient names from the database largely eliminated the possibility of disclosing an individual’s identity. Presenting the data in aggregate form greatly reduces the potential of identifying an individual patient, even if that person is long deceased. Combined, these precautions should minimize the risk of exposing an individual patient’s identity or causing more discomfort than encountered in everyday life.

Bibliographic Essay

As a historian, I am constantly on the lookout for a compelling story. Even better, I dream of finding compelling stories that have not been widely told. The history of the Daughters of Charity in Los Angeles contains all the elements of a great story: a little drama, a lot of adversity, and more than a little hope. As a case study that mirrors the history of the city, the sisters’ story is a historian’s dream. I stumbled upon this story at L.A. as Subject’s Archive Bazaar in late 2006. As a graduate student looking for a new angle on California women’s history, I attended the bazaar hoping to pick the brains of the archivists who represented dozens of repositories throughout greater Los Angeles. Among the exhibits, I found the St. Vincent Medical Center Historical Conservancy. Intrigued, I later set up an appointment with the conservancy’s archivist, who introduced me to the sisters’ history. Fascinated with the story’s possibilities, I quickly determined that I had to know more. And that, as they say, is history—or at least a dissertation, and now, a book.

Reconstructing the sisters’ story in a scholarly way required the creative use of available sources, as well as the much more difficult task of assessing the silence. The community’s rules encouraged sisters to avoid “singularity,” or bringing attention to themselves as individuals instead of focusing on the mission of the community. As such, sisters rarely spoke in public, kept personal journals, or signed their writings. Often, the only public record of an individual sister’s presence in a house was the decennial census, and even then, census-takers rarely recorded the sisters’ last names. Few records remain of the average sisters’ experience in their hospitals, orphanages, and schools. Frontier conditions, and the sisters’ heavy workloads, complicated matters further in southern California as few had the time or resources to keep extensive personal records.

However, these women are not forgotten to the community, and the Daughters of Charity retain a sense of history. The centralized organizational structure of the community required local sister servants to report their activities to the provincial director or visitatrix, who then summarized the efforts of all the institutions and reported them to the community’s international headquarters in Paris. In the nineteenth century, these reports generally took the form of personal correspondence. During the 1850s and 1860s, Sister Scholastica Logsdon corresponded extensively with Father Francis Burlando, the Vincentian director of the Daughters in the United States. Her successors wrote letters to the visitatrix, the sister charged with leading the province. By and large, the provincial house kept these letters, and they form the basis of the historical record for each institution.
The provincial house also maintains the minutes from provincial council meetings, and brief biographical records on sisters serving within the province. These records often contain birthdates, birth names and places, dates when women joined the community, locations where they served, death dates, and whenever possible, burial places. In this way, the Daughters remember the individual women who served in the community and their collective activities at institutions throughout the country.

The sisters’ archival collections vary according to the needs of the institution, its activities, and the relative importance of record-keeping and historical preservation over time. Historical materials are kept by each institution, although St. Vincent Medical Center is unusual because it maintains an active archive. Each province also maintains a regional archive. Originally the Daughters of Charity only had one province in the United States, headquartered in Emmitsburg, Maryland. However, the province divided in two in 1910, and Los Angeles then belonged to the Western Province in St. Louis. The two provinces divided into five in 1969, and the Los Angeles missions then belonged to the Province of the West, headquartered in Los Altos Hills, California. Each time the provinces divided, the sisters moved the records for each mission to the new provincial headquarters. Sister Scholastica’s letters which were originally housed at St. Joseph’s in Emmitsburg are now located at Seton Provincialate in Los Altos Hills. In July 2011, four of these provinces recombined to form the Province of Saint Louise, and they are in the process of consolidating their archives into a single location at St. Joseph’s in Emmitsburg. The sisters in the Province of the West, headquartered in Los Altos Hills, decided to remain independent. Currently, the Daughters of Charity maintain two provinces in the United States, the Province of Saint Louise and the Province of the West.

While the provincial archives contain the sister servants’ correspondence, historical material at the local level is varied. While most of the material regarding the hospital’s development is housed in the St. Vincent Medical Center Historical Conservancy (SVMCHC), the sisters also left an economic imprint in the region’s historical materials as business owners. Since Benjamin D. Wilson sold the sisters the original orphanage property, his papers at the Huntington Library help to clarify some of the economic issues surrounding the sisters’ establishment in Los Angeles. In addition, the Los Angeles Orphan Asylum and Los Angeles Infirmary incorporated on 21 June 1869, and as benevolent corporations, they had to petition the Superior Court to buy or sell real estate. The Huntington has records of these transactions in its LA County Court Records collection. Sister Scholastica also purchased property in her own name in 1858 and 1861, a fact which could only be verified through the LA County Deed records. These records are currently housed at the University of Southern California; however, they have not been processed as yet. But, I was able to access a microfilmed copy of the deed records from the LDS Family History Library in Salt Lake City, who microfilmed the records when they were at the Santa Monica Historical Society in the 1990s. Property transactions often remained unclear in the sisters’ records, and it would have been impossible to accurately understand the negotiations surrounding the sisters’ property without seeing the names and dates on the actual deeds.

Besides considering the sisters’ social and economic connections, I also believe that it is important to place their institutions in an appropriate legal and political context. Since American social welfare traditions intertwined public and private responsibility to care for the poor, the Daughters of Charity operated within a framework set up by the state. By the 1870s, care for the indigent sick became highly politicized in California, and this directly affected the sisters’ hospital in Los Angeles. Throughout the 1860s, counties negotiated with the state legislature about which government entity had the primary responsibility to fund the care of the indigent sick. Then, the 1869 smallpox epidemic raised city and county health care costs exponentially, prompting the Los Angeles County Board of Supervisors to petition the legislature for additional state aid. Since the legislature approved all bonds for county indebtedness, it also had the power to define what type of facilities would receive its approval. Thus, state politics likely influenced LA County’s decision to establish a hospital and poor farm in 1878, a decision which also distanced the supervisors from the Daughters. The legislative journals were also helpful in sorting these issues out, and more relevant material may be found in the State Board of Health's records.

In addition to searching records at the state level, county records also proved helpful (although at times elusive) in analyzing the sisters’ relationship for the rapid growth of the community in the late nineteenth and twentieth centuries by dividing the provinces, or administrative units. Dividing the province allowed the community’s leadership to provide more personal attention to the sisters and institutions under their supervision. Each province had its own Sister Visitatrix and Vincentian director, although the visitatrix had taken on most of the daily responsibility of leading the province by 1900. In the administrative structure of the community, all provinces are equal and the visitatrix reports directly to the Superioress General in Paris; she is not under the authority of any other visitatrix in the United States. In 1910, the Province of the United States divided into the Eastern and Western provinces. The Eastern Province was headquartered in Emmitsburg, Maryland, while the motherhouse of the Western Province was established in St. Louis, Missouri. In 1969, the provinces divided again. Five provinces were then established. The Northeast province was headquartered in Albany, New York; while the Southeast province remained at Emmitsburg; the East Central province was headquartered in Evansville, Indiana; and the West Central province remained in St. Louis. After the division, California, Oregon, Washington, Arizona, Colorado, Utah, and Nevada belonged to the Province of the West, whose motherhouse (named Seton Provincialate) was located near San Jose in Los Altos Hills, California. Hannefin, Daughters of the Church, 191-195, 250-254, 301-302.

[488] The Daughters of Charity compensated for the rapid growth of the community in the late nineteenth and twentieth centuries by dividing the provinces, or administrative units. Dividing the province allowed the community’s leadership to provide more personal attention to the sisters and institutions under their supervision. Each province had its own Sister Visitatrix and Vincentian director, although the visitatrix had taken on most of the daily responsibility of leading the province by 1900. In the administrative structure of the community, all provinces are equal and the visitatrix reports directly to the Superioress General in Paris; she is not under the authority of any other visitatrix in the United States. In 1910, the Province of the United States divided into the Eastern and Western provinces. The Eastern Province was headquartered in Emmitsburg, Maryland, while the motherhouse of the Western Province was established in St. Louis, Missouri. In 1969, the provinces divided again. Five provinces were then established. The Northeast province was headquartered in Albany, New York; while the Southeast province remained at Emmitsburg; the East Central province was headquartered in Evansville, Indiana; and the West Central province remained in St. Louis. After the division, California, Oregon, Washington, Arizona, Colorado, Utah, and Nevada belonged to the Province of the West, whose motherhouse (named Seton Provincialate) was located near San Jose in Los Altos Hills, California. Hannefin, Daughters of the Church, 191-195, 250-254, 301-302.
with the Los Angeles County Board of Supervisors during their twenty-year partnership. LA County does not have an official archive, but does offer scholars access to their materials at the Executive Office of the Board of Supervisors downtown. In 2007, I requested to see the minutes of the Board of Supervisors from 1850 to 1880, hoping to discover the reasons why the board decided to end their partnership with the Daughters of Charity in 1878. Unfortunately, only two of the requested books arrived, those from 1852 to 1860. The other books had been temporarily misplaced. After a formal investigation, the county's record management company found the missing boxes in late 2009, and I was able to complete my research. Combined with the printed reports published in the Los Angeles Herald, the minutes set the context for the supervisor's decision to build a new hospital, including increased demands from indigent persons for county aid and an attempt to modernize the city through subsidizing the Southern Pacific Railroad. The minutes also revealed the county's actual costs for hospital care, thereby allowing me to begin to assess the oft-repeated charge that the sisters treated patients “too well” and cost the taxpayers too much money.

The county records, newspaper reports, and court petitions helped me to fill in some of the gaps in the sisters’ records regarding the Los Angeles Infirmary. Unfortunately, Sister Ann Gillen's letters to her superiors in Emmitsburg have not survived, so it is impossible to truly know how she and the other sisters felt about the dissolution of their partnership with the county. Nor is the corporate minute book much help, as it also remains silent on the matter. However, SVMCHC does have the hospital admissions books from 1872 through the 1930s. From the 1870s admissions book, historians can determine the number of people who used the hospital, the percentage of charity patients, their gender, age, nationality, and last place of residence. Subsequent admissions books also contain patients’ occupations, a list of attending physicians, and a brief diagnosis. From this mountain of data, historians can assess changes in the hospital's use over time, particularly as it relates to the type of people using the hospital, their ability to pay, and the type of diseases treated. Sisters’ Hospital also treated sick and injured employees of the Southern Pacific and other railroads in the 1890s, and analyzing this data provides a better understanding of how these pioneer health insurance programs functioned on the ground. These hospital admissions books are particularly important because Southern Pacific General Hospital in San Francisco burned in the 1906 earthquake and fire, leaving a paucity of records about the institution. The admissions books from Sisters’ Hospital help bridge the gaps in this facet of medical history in California.

Despite the advantages of using hospital admissions records, today's privacy laws make access to them complicated. Because SVMCHC is part of an active hospital, some concern arose about whether or not the historical admissions books were covered by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). After some additional research and discussion, the hospital and archive determined that records over one hundred years old did not fall within the parameters of the Privacy Rule, and I was allowed to use the admissions records between 1872 and 1908, as long as I minimized the risk of potential exposure of individually-identifiable health information (see Appendix B).

As time passes, more data will become available. Since the level of detail in corporate records tended to improve in the 1910s and 1920s, the data from later admissions books could open a new avenue of research for historians. In particular, it may be possible to conduct a social-spatial analysis using Geographic Information Systems (GIS). Linking demographic data in time and space enhances scholars' understanding of social trends and processes. Using GIS, it may be possible to analyze the contributing factors to a patient's choice to be treated at the Los Angeles Infirmary (known as St. Vincent's Hospital after 1918). Religion is often assumed to be the motivating factor, but distance, choice of physician, modern hospital facilities, and the sisters' reputation for quality care may have also played a role in patients' decisions. The data contained in the admissions books might provide evidence for this sort of analysis, and this research technique could potentially enhance scholarly methods for the study of history as a whole. Unfortunately, the data recorded before 1908 is not sufficiently detailed to effectively conduct the analysis, so scholars will have to wait until more becomes available before attempting this type of research. Nevertheless, the hospital admissions books provide information that significantly improves scholars' understanding of the development of hospitals in Los Angeles in the late nineteenth century.

Even though I was not able to utilize GIS, printed maps proved useful in illuminating the sisters' place within the social geography of Los Angeles. The Sanborn Fire Insurance Company Maps, available in black and white through Proquest Research Databases, and in color at the CSU Northridge Map Library, situated the sisters' institutions within their neighborhoods. Through the maps, I learned that the sisters had a chicken ranch at the Sunset hospital, and that the sisters added an additional operating room in 1902. Combining maps with other historical materials reveals relationships between place and space that might otherwise go unobserved. Photographs can illustrate similar relationships, and I also included the photo collections at SVMCHC and USC Digital Archives in my analysis.

Although SVMCHC has copies of some of the sisters' early materials, most of its collections date from 1880. They include newspaper clippings, the corporate minute books, some correspondence, the hospital admissions books, and nursing school materials. Some of the most interesting items are the annual
reports (1913-1945). The reports not only summarize the financial condition of the hospital, but are also the only accessible record of the sisters’ charity work beyond patient care. The sisters visited hundreds of families in their homes, and thousands sought them out to request food, clothing, or other assistance. Neither the sisters nor the press discussed individual acts of charity, so the annual reports are essential to begin to substantiate the full extent of their charitable activities. More material of this type may be included in the provincial archives in Los Altos Hills or Emmitsburg, or possibly in the sisters’ international archives in Paris.

While the archival collections at SVMCHC focus mainly on the period after 1880, the materials from the 1850s and 1860s are housed at Seton Provincialate in Los Altos Hills. These include Sister Scholastica’s letters, her diary of the voyage to California, Sister Polycarp O’Driscoll’s letters from Santa Barbara, and the journal and diary of the sisters who came to San Francisco in 1852. While I was granted extensive access to the collections at SVMCHC and Maryvale, the provincial archive’s policies restrict research to copyrighted material. Gratefully, the archivist had compiled and edited a collection of most of the early letters, and she generously assisted with research and helped me to understand the material better. However, there was some material which was not available for research, particularly the original letters written by Father Francis Burlando and Bishop Thaddeus Amat. I was, therefore, forced to rely on published excerpts from the letters contained in Ellin Kelly’s Numerous Choirs, volume two (1996), although the archivist did verify the quotes against the originals.489 The archives of St. Joseph’s Provincial House in Emmitsburg have similar policies, so most of the relevant material there was also unavailable for research. However, the archivist was very helpful in providing biographical information about the sisters, and in suggesting additional resources I could consult to better contextualize the sisters’ experience in Southern California.

Throughout my work, I seek to place the Daughters of Charity within the larger history of women in Southern California. By analyzing their business dealings at the hospital, I further extend scholarly understandings of women’s economic activities in the region. But, I also feel that it is important to situate the Los Angeles sisters within the history of the Catholic Church in California, and within the history of their religious community. Because the rules and traditions of the Daughters of Charity inform nearly every aspect of the sisters’ lives, I sought to incorporate the community’s philosophy into my analysis. Published copies of the community’s rules are available in volume 13b of Vincent de Paul: Correspondence, Conferences, and Documents (2003). For a scholarly analysis of the development of the community, Susan Dinan’s Women and Poor Relief in Seventeenth-century France (2006) proved useful. When assessing the American context, I used Sister Daniel Hannefin’s Daughters of the Church (1989), Ellin Kelly’s two volume Numerous Choirs (1981 and 1996), and Martha Libster and Sister Betty Ann McNeil’s Enlightened Charity (2009).490 These and other works provided a foundation from which to tell the California story.

Overall, researching the history of the Daughters of Charity has been like a treasure hunt, a thrilling intellectual activity for any historian. The sisters’ position as the primary social service provider in nineteenth-century Los Angeles opened multiple avenues for research into women’s history, religious history, and medical history in the West. It also offered an entry point into discussions about the relationship between private charity, social welfare, and the state in the nineteenth and twentieth centuries. The research required me to think about sources in new ways and to develop new skills such as statistical sampling. But in finishing this project, I realize that I have just started to scratch the surface of this rich history. There is more to be uncovered and rediscovered, and this is the first of many compelling stories about the Daughters of Charity that I hope to be able to share.

489 Kelly, Numerous Choirs, vol. 2.

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