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1. The Labor of Love: Vocational Commitments in the Hospital

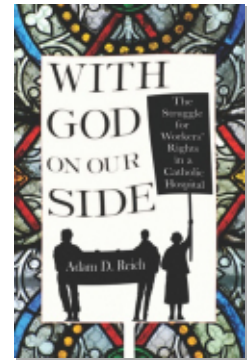
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THE LABOR OF LOVE

Vocational Commitments in the Hospital

Fred Ross and Eileen Purcell had known the Sisters of St. Joseph of Orange, the owners of the St. Joseph Health System, since the heyday of the United Farm Workers movement. In 1973, several of these sisters had gone to jail with striking farmworkers in Fresno. Since then, many had worked alongside Ross and Purcell for justice in El Salvador. In the late 1980s and early 1990s, the Sisters had supported the Justice for Janitors campaign in Los Angeles, and in 1995 one sister had founded Taller San Jose (St. Joseph's Workshop), a job-training program for at-risk youth in Santa Ana, California. It would have been more surprising had Ross and Purcell been able to *avoid* being familiar with these nuns, whose social justice legacy was well known across California.

An Introduction to the Sisters of St. Joseph of Orange

The Sisters of St. Joseph established themselves sometime between 1646 and 1651, when a Jesuit priest named Jean Pierre Medaille first arrived in

Le Puy, France, and helped to organize a lace-weaving cooperative among a small group of starving and war-ravaged women. As the legend goes, the women were able to support themselves on the proceeds of the trade, and dedicated their spare time to nursing the physical and spiritual needs of others.¹

Whereas nuns traditionally had come from wealthy families and remained cloistered, or closed off from the outside world within convents, beginning in the seventeenth century a number of uncloistered communities were founded. In France alone, eighty such communities of nuns sprang to life between 1630 and 1720.² The Sisters of St. Joseph were one of these early groups of religious women, women who came from more modest backgrounds and who lived out their spirituality through works in the community.³ Saint Vincent de Paul, one of the earliest proponents of this active ministry among religious women, is thought to have said to another uncloistered community, the Daughters of Charity, “When you leave your prayers for the bedside of a patient, you are leaving God for God. Looking after the sick is praying.”⁴

The culture of the founders has remained remarkably resilient across time and place. For the Sisters of St. Joseph, one of the first orders made up of ordinary women, and one of the first to reject the cloistered life, spirituality is something brought to life in the sweat and toil of good works. As they arrived in the United States in the mid-nineteenth century along with other orders of Catholic women from France, Ireland, Great Britain, Germany, and Poland, these religious women represented “a hybrid form—pragmatic and worldly, vocation-driven and deeply religious at the same time.”⁵ Their successful institution-building and care for the poor made them the most visible ambassadors of the Catholic Church to an often-suspicious Protestant majority;⁶ many of those Protestants most skeptical of Catholicism made an exception for these religious women.⁷ Catholic Hospitals also gave nuns important sources of institutional and spiritual autonomy from the male-dominated Catholic Church, especially for those orders—like the Sisters of St. Joseph of Orange—that were structured around a central motherhouse rather than around a local diocese.⁸

In 1918, the Sisters of St. Joseph of Orange began caring for the sick and poor in the small community of Eureka, California. A delegation of sisters had been sent there from their headquarters in Orange, California, to found a school, but saw the local community being ravaged by the global

influenza pandemic that ultimately killed 50–100 million people worldwide. In response, they began visiting people's houses, and eventually set up what would become St. Joseph's Hospital. But despite their efforts, the Sisters faced the skepticism of a recently professionalized medical community, who "were reluctant to bring their patients to St. Joseph's, for they believed the Sisters were untried and uneducated."⁹ It was only through three years of arduous work and training that the "rooms were filled and . . . ledger books indicated that the convent would be enjoying some financial security."¹⁰ Over the next several decades the hospital system grew—to four hospitals by 1933, and to nine by 1964; throughout this period the Sisters themselves held nearly all of the administrative and staffing positions in their facilities.

Just as the Sisters of St. Joseph of Orange established themselves in Eureka, sisters throughout the United States mixed selflessness and vocational devotion with business sense and political acumen. On the one hand, sisters found deep spiritual meaning in patients' physical vulnerabilities, and fluidly mixed the care of patients with their own religious practice.¹¹ On the other hand, these same sisters transformed "overwhelming social need into opportunities for the development of health care services to the American public," and established themselves as among the earliest female entrepreneurs in the United States.¹² During the nineteenth and early twentieth centuries, women's decisions to join religious orders were often connected to considerations of economic power in a world of precluded possibilities.¹³ Indeed, it was Sisters' religious identity, sexual chastity, and relative anonymity that allowed them the institutional space to build their own organizations within a broader patriarchal society,¹⁴ freeing them up to act "like men" well before other women of their time.¹⁵ For example, Sister Jane Frances Power, mother superior of the Sisters of St. Joseph of Orange beginning in the late 1960s, was the first female head of the Southern California Hospital Council beginning in 1964 and the first president of the St. Joseph Health System. Describing her, a former sister said, "Before I knew that there could be women who just manifested more masculine traits, and they still were women in every bit of themselves, I would have said 'She should have been a man.'"

Catholic hospitals exemplified the midcentury ideal of selfless voluntarism, an ideal that shaped hospital practice and policy nationwide. Catholic hospitals relied on the low-wage labor of the nuns.¹⁶ But the

idea of voluntarism in hospitals stretched beyond the Catholic hospital as well. In secular hospitals, auxiliaries—or unpaid volunteers—made up for what the organizations lacked in religious zeal. As late as 1961, there were 1.2 million members of such auxiliary organizations (most of them women), which was not far from the total number of paid employees. These volunteers, like the nuns in Catholic hospitals, brought to life the idea of the hospital as a local community institution, and the idea that hospital work was something done for more than economic motives.¹⁷

Even today, nuns continue to be free from the demands of husbands and children, independent from obligations to the “private sphere.” Their commitment to God seems to provide a kind of legitimacy to their femininity—a marriage to Christ.¹⁸ And so, somewhat paradoxically, they remain in some ways less constrained by conceptions of femininity than other women are, and more free to engage in the public sphere wholeheartedly.¹⁹ Because of their unique capacity to be both moral leaders and entrepreneurs, nuns remain influential players in a hospital industry that profits in part from being seen as something *more than just an industry*.²⁰ As one indicator of this influence, Sister Carol Keehan, president and chief executive officer of the Catholic Health Association (CHA), was named the most influential person in healthcare by the trade publication *Modern Healthcare* in 2007.

A potent mix of business and spirituality continues to infuse the way that Sisters and lay executives in the St. Joseph Health System explain the organization’s day-to-day work. According to one system executive, “It’s very easy to define your actions in terms of the environment and the market. . . . But we try not to ever approach a problem from the viewpoint of the market, but from the viewpoint of the ministry, operating within a certain market.” A nun on the executive team explained how the system was always deliberate about “framing it” in such a way that the “finances are what supports [us] doing the ministry.” She spoke of the administration’s responsibility as “stewards,” adding that “what we have to steward is way more than money. It’s reputation and history, the people that are involved, all of the assets, the buildings, the facilities, the good name in the community.”

What does it mean for the ministry to take precedence over the market within the operations of the hospital system? One executive explained: “We believe that the experience of interacting with us has an opportunity

for a sacred encounter, sacred meaning. You walk away from the encounter more whole than you came into it, whether you [are] a vendor or an employee or a physician.” Recognizing the challenge of institutionalizing the sacred encounter in a system with thirteen hospitals and over twenty thousand employees, the Sister emphasized the importance of spiritual “formation”:

We have been striving to give people the opportunity to reflect on what a “sacred encounter” is. That’s formation. “When did you feel respected, healed, whole by an interaction with a person? When do you think you’ve been able to be an agent of that for someone else?” That’s the kind of reflection.

Another executive acknowledged that this sacredness was hard to measure. Still, the system had been working to take “particular moments in the patient experience” and explore how to make them more sacred. For example, she explained, “One of the places we realize that there’s a real opportunity for sacredness is around the birth of a child. So we’re looking at that moment and saying, ‘What do we do in that particular moment that enhances the opportunity that it be perceived as a sacred experience?’” The sacred encounter provided an orienting vision among the hospital leadership about what kind of environment they should be striving toward.

Sacred Encounters from the Bottom Up

When workers described what connected them to the hospital, very few addressed the religious nature of the work explicitly. But the idea of sacred encounters was echoed in their descriptions of those social dimensions of their work that they valued most—a connection to patients, to one another as they worked on behalf of patients, and to the kind of collective effervescence that arises when people rally together in times of uncertainty and crisis. The sacred encounter, as an ideal, seemed to resonate with workers’ investments in the work they did.

Louise, a licensed vocational nurse and union leader, echoed the sentiment of some nuns when she discussed changes in nursing she had observed as nursing pay had increased: “People started going into nursing that really had no business doing it, they did it because the money looked

good. And so they didn't have the calling to be a nurse." It "shows in the way they relate to patients." In explaining what was missing from those nurses who "didn't really want to do nursing," Louise described the personal, social, and psychological dimensions to nursing work that go beyond the daily requirements of the job. When a person has a trauma to his or her body, she went on, "there's a big mental thing you go through," fears of never feeling normal again. Yet "some people won't ask you those things . . . that's too embarrassing to ask you." It was only through "getting personal" that nurses were able to draw out and address these fears: "By giving somebody a bath and washing their hair, you're teaching them all the time you're doing that."

Workers at a hospital are surrounded by people coming to terms with their own limitations and, in some cases, their mortality. Although there is certainly variation in the ways that workers relate to this emotional intensity, many felt that it made the work more meaningful and more significant to their own lives than if this aspect of work had been absent. Louise explained how, in the hospital, "We take everything away from them. We tell them when to eat, when to sleep, when to get up and sit in a chair, when to walk around the halls. They don't really have a say." She suggested that this loss of control was especially hard for men, who are "used to being really independent." Rebecca, a unit secretary at the hospital, said that one of the facets of work she enjoyed most was "being involved with people in a very sort of intimate way. Just seeing them as no one else sees them and being able to know that I know them and that they know and trust me." Frank, an anesthesia technologist, felt the weight of the responsibility: "Somebody's gotta be their advocate because they're at their most vulnerable when you get them. They're trusting you with their lives. You're going to put them into unconsciousness and they're going to trust you to take care of them." George, a respiratory therapist, distinguished between the cerebral and the emotional aspects of his job:

There's numbers, a person has a pulse, a person has a breath rate and a breath sound. But they also have a psycho-emotional part of them that's dealing with the vulnerable, compromised state that they're in. Whether it's having a hard time breathing, with asthma, or being in a trauma and being banged up and being on a breathing machine and being really afraid.

He described a patient who had been hit by a truck while leaving work one day and had been flown by helicopter to the hospital. While she could not write or speak, George remembered that “she was very much there, I could see that in her eyes,” and saw that she was “distraught” and “frustrated.” George knew of an underutilized valve that he could use to let someone speak even while on a breathing machine, and convinced the trauma surgeon to insert it. “And she was able to talk—you know, and express, ‘This hurts, that hurts, I’m hungry, I’m this, can I have that, what’s the next step?’” Combining his technical expertise with his emotional attunement, George was able to give this patient her agency back.

The emotional intensity of hospital work creates a particular kind of community among workers at the hospital. Mari, an obstetrician technician, remembered that “many times when we lose somebody we cry, we just hug each other, and we got to continue with it.” Because of this intimacy, “it is a family, you become a family” with your co-workers. Yet workers’ sense of the importance of their work was not necessarily related to their proximity to patients’ vulnerability. Describing what she likes about her work, Cynthia, an imaging technician, said, “The service that we’re administering is for the most part clear-cut about its needs; it’s not like you’re making a widget that no one really needs.” Her skill was one that had a clear and immediate role in helping people get healthy, even though her direct interactions with patients were limited. José, a kitchen worker, had a similar feeling about what he did:

What we do directly affects how the patient heals and gets better throughout their stay at the hospital. Doing day to day the work to get those meals ready, to get those plates clean for them, to be sanitized for them to be ready for the next meal, plays a big role in nourishing the patients. I may not have that contact but I think I play a part in it because we’re all connected, you know, because if we don’t provide them food we’re not gonna heal them properly.

Even without personal, emotional connections with patients, workers in the hospital felt connected to something significant. Workers’ feelings of emotional investment in their work meant that they were often willing to do more for their patients than required of them by their jobs. Louise explained how she went out of her way to make sure that dying patients had their needs met:

If they need to talk to everybody in their family and want to talk on the phone or whatever, you need to provide that for them, even if that means taking your damn cell phone and giving it to them. “Yeah, you can’t make long-distance calls out of our hospital, here’s my cell phone. Call everyone you need to call.” Because you have to do what it takes.

More significantly for the hospital’s bottom line, workers are often willing to work longer hours than those for which they are paid. Louise said that she’d rather “stay over and be late [getting] home” than let her patients be without something they needed. Rebecca admitted that she rarely took her break because her “main objective there is to make the patients get the best possible care.” Frank remembered how he “gave [the hospital] a free hour every day for seventeen years to make sure that when the anesthesiologist got there there was nothing that they needed.” This “free labor” is consistent with the voluntary ethos fostered by the hospital administration, but also seems structured into the nature of hospital work itself. Nurses are often cited by managers as exhibiting a reverse labor supply curve, in that the more they are paid the less they work, choosing to substitute leisure or family time for more hours on the job.²¹ Although that doesn’t hold up empirically,²² workers’ accounts at Memorial Hospital hint at an inverse curve of a different sort, as those people who feel so deeply connected to their work might be willing to put in *more* hours than those better compensated for whom the job is “only a job.”

When the Sisters were an active presence at the hospital, they served as the example of a vocational commitment to hospital work. And while they had already begun to withdraw from daily work at the hospital by the time most current employees arrived, several workers recounted fondly the administrative roles that the Sisters continued to play. Louise remembered how the Sisters served as an emotional resource for patients: “I could always call them and say, you know, ‘This person’s having a really tough time, could you come over and just talk to them?’” But the support the Sisters provided Louise herself was just as important to her. Recalling how difficult it had been when she had patients pass away as a young nurse, Louise said, “They would seek me out in the lounge and ask me, ‘Are you doing okay? Do you want to talk to me? I know you had a relationship with that patient, and how are you doing?’” Sisters’ concern for their employees went beyond the workplace as well. Louise remembered

how they asked her how her kids were and how she was doing as a single mother. Bettie, who works in Central Supplies, remembered that “people depended on them and they knew that they could go to them. They actually honestly listened to you and tried to help you.”

While the Sisters were still actively administering the hospital, workers also felt that they had a means to discuss the difficulty of their jobs and come to collective solutions. One administrator, Sister Phyllis, would hold open meetings at which workers could talk about what was going on. Rebecca recalled how “people would be crying about how they wanted [more time] to care for the patients. And Sister Phyllis would follow up with everybody and try to see that the situation was rectified.” These meetings would often stretch over several hours, giving space so that “everybody in the room who wanted to talk got to talk.” Alexis called the Sisters “the conscience of the hospital,” a buffer against financial concerns: “Whenever the hospital administration would start getting greedy and start thinking about money versus people, the Sisters would kind of go, ‘Wait a minute, that’s not how you treat people.’” Even as the Sisters’ presence in the hospital diminished, Alexis seemed to think of them as guardian angels. Long after the Sisters had left active administration, there was a rumor going around the hospital that a Sister had played a part in getting a bad manager fired. This Sister, still involved in a local Catholic school, had seen the manager as a parent, “saw that her son was afraid of her,” and then heard about her employees being unhappy. “I think [she] put two and two together and said, ‘Yeah, this is somebody we don’t want around here.’”

For several employees, the Sisters’ religious conviction resonated with their own values even more directly. This was especially true among some Latinos at the hospital who were also practicing Catholics. Rosanna, a Latina medical translator, appreciated the chapel in the hospital and the visible presence of Catholic symbols and values. When her biological sister offered to help get her a better-compensated union position at a nearby facility, she declined. José also felt some resonance between the Catholic values of the hospital and his own values growing up: “Going to mass and church school, I mean, it really influenced me in the way I think and the way I carry myself.” Soon after he began working at the hospital he realized that this work compelled him more than other kinds of service jobs he had worked before because of the way he was able to help out those in need, “nursing them with good food.”

The Mission Meets the Market

Even those employees who remembered the good old days of the Sisters' involvement had arrived at the hospital during a period of flux in both the organization of healthcare and the organization of the Catholic Church. The passage of Medicare and Medicaid in 1965, and the large infusion of money into hospital care that followed, created a bountiful new environment for healthcare in the United States—an environment that was somewhat disorienting for the Sisters of St. Joseph of Orange. According to a history of the Sisters of St. Joseph of Orange, by the 1960s they were asking themselves, “Where did the vow of poverty fit into all of this material success?”²³ In 1967, the Sisters' monthly allowance jumped from approximately \$30 (in 2005 dollars) to approximately \$150. “It was the older Sisters . . . who had difficulty with this concept. They had never been asked to express any of these needs—how could they even imagine what they would use in the way of material goods?”²⁴ This relative opulence was accompanied by a loosening of other strictures. In response to Vatican II, in 1968 the Sisters retired the habit, were allowed to live in apartments away from the community, and were allowed to spend their leisure time more or less as they desired.²⁵

But the opportunities within Catholic healthcare and the Catholic Church paled in comparison to new opportunities in the world at large. The social upheavals of the 1960s and 1970s far exceeded the new allowances of the order, and nuns began to exit in significant numbers. That decline has continued to this day. The written account records that during this era “a growing number of the positions [in the health system] were . . . being filled by lay persons.”²⁶ Concerned that the hospital system not lose “Christ's healing ministry,” yet not wanting to “impose their views on the increasingly diverse individuals that made up the bulk of their employees,” the Sisters defined what values were most important to them as an order and then asked employees to define how they would live out these values. The Sisters' active presence in the hospital would decline, but they would still “retain full ownership of the hospitals, and also would select the . . . Board of Trustees, approve financial officers, and control the budget.”²⁷

Jill, a former nun with the Sisters of St. Joseph of Orange, remembered how exciting and uncertain a time it was for women in the order. While sisters were permitted to “shed the habit and wear street clothes,

I didn't want to do it," she recalls. And "when they went to Delano" to support striking farmworkers, she didn't go, "not because I didn't agree that the workers should be able to strike, [but because] I was afraid." The order's new engagement with the outside world also meant that it put a premium on Sisters' ongoing education, sending several to the East Coast for doctoral education in the 1960s and 1970s. According to Jill, the new academic opportunities for a few Sisters indirectly exposed all of them to new ideas:

It meant that they were going to be with a lot of people who weren't in community and so learn other ideas, experience other things and so they came back and they brought a lot of that back to the community and they were actually the ones in the '60s that were pushing for change in community and change in the church.

These Sisters would bring modernity to the order, and represent the order in a modernizing world.

The Sisters' relationship with their hospitals began to change in some subtle ways as well. In the early years, with ready new cohorts of young recruits to staff the orders' hospitals and schools, the Sisters were able to support themselves in the cooperative manner of their founders. Sisters were given a nominal monthly salary, most of which went to a collective pot that would be used to pay for all Sisters' food, housing, and medical care. Yet where the Sisters who served as teachers were given approximately \$60 a month when Jill worked, the Sisters in the hospital were given a salary equivalent to lay staff, which came out to be "a lot more." Therefore, while there were many more Sisters working in the schools than in the hospitals, all of the Sisters knew that "it's the hospitals that support you."

The division between teacher Sisters and hospital Sisters only deepened as the numbers of new recruits ebbed and the order came increasingly to rely on the profits from the hospital system to support itself. A new generation of Sisters in the hospital challenged the stereotype of the nun as an epitome of selfless femininity. Instead, those Sisters still involved in the hospital system were business-savvy executives. As a whole, Jill remembered, the Sisters involved in the hospital "didn't feel as sensitive, or as warm" as the Sisters involved in teaching. Moreover, the order would select the "more brilliant" Sisters from the ranks of the teachers and recruit

them into the hospital system. Of those Sisters who received their doctorates, Jill remembered, many had been teachers before graduate school, but “not one of them went back to teaching.” Paradoxically, it was the same spirit of engagement with the world that led the order both to its commitment to social justice and to its entrepreneurship in the hospital industry.

The steep decline in new recruits to the Sisters of St. Joseph of Orange, and to orders across the country, has continued with the same ferocity as the nation’s acceleration in healthcare spending. According to a 2009 study by the Center for Applied Research in the Apostolate at Georgetown University, over 90 percent of U.S. sisters were sixty or older,²⁸ meaning that only a small percentage of sisters are now able to work. In Orange, California, a large retirement complex sits next to the Sisters’ motherhouse for those Sisters now old and infirm. According to Purcell, the hospital system has become “not only a safety valve but also institutional parity. . . . It gives them standing in the institutional Catholic Church that has systematically disenfranchised them and taken no strides—until relatively recently—to protect them in their old age.” The hospital system continues to provide both an important nest egg for retired Sisters and some degree of equality with men in the Church to whom they have so long been subordinate.

Changes in the organization of American medicine and the internal dynamics of religious orders put new sorts of pressures on all Catholic hospitals over the second half of the twentieth century. Barbra Mann Wall, a professor of nursing, describes these changes as “analogous to the crisp black and white colors of nuns’ habits blending slowly into shades of gray.”²⁹ New competitive pressures meant it was more difficult for Catholic hospitals to maintain their religious commitment to the poor and underserved.³⁰ Moreover, these pressures, combined with declining numbers of sisters nationwide, meant that administrative obligations were increasingly transferred into the hands of lay leadership,³¹ and Catholic hospitals that were once run relatively autonomously were forced to consolidate into multistate, multibillion-dollar hospital systems. In 1981, the Sisters of St. Joseph of Orange integrated their hospitals under the umbrella of the St. Joseph Health System. These Sisters, along with Catholic healthcare institutions around the country, were being forced to reevaluate how religious values might be translated into modern healthcare practice.

Maintaining the Mission

In 2007 the last two Sisters at Santa Rosa Memorial Hospital left their posts to move north to Eureka, meaning that the hospital's relationship with the order attenuated even further. Still, the Sisters were not content to benefit financially from the hospital while allowing it to be transformed entirely into a business. For one union leader, the premium the Sisters placed on their legacy seemed closely related to the fragility of the order itself: "Legacy and memory become important to people who are dying. It's a funny thing. It's almost as if we think if we're remembered we will still live and if we're not remembered we'll die."

When I sat down with a medical administrator at the hospital, he told me about steps the Sisters had taken to preserve their legacy in the hospital's daily practice:

And so now the Sisters have said to me and to my partners, my fellow administrators, "You're in charge. And we expect you to operate this hospital as we would, in keeping with the traditions of the Sisters of St. Joseph. We want you to go into the community, we want you to do good, we want you to take care of people who are unfunded and underfunded. We want you to improve the health of the community."

As a part of this process, St. Joseph Health System had paid for him and other administrators to "go on a pilgrimage" to Le Puy, to learn "about the founders and how awful life was in 1650." More concretely, a cadre of multid denominational chaplains continues to minister to the emotional and spiritual needs of patients, and the sanctuary at the hospital—with sun filtered through large stained glass windows—is so beautiful that a group of local Catholics has adopted it for daily mass.

St. Joseph Health System maintains in each of its facilities a department of mission integration, focused on ensuring the consistency of the Sisters' theology and hospital practice. A few years ago, the Sisters' first hospital in Eureka was in dire financial straits, but according to one executive it was "the only major provider in that area." As he perceived it, "Anyone else looking at the financial side of it would have exited the market because it just didn't make any sense." But SJHS "looked at the community, and we looked at who we are and we made a decision to stay in that market."

For an ethicist who works for the system, the fact that SJHS dedicates “a significant amount of money” to treat the uninsured was evidence of the ministry in action. He continued, “I’m sure there’s not a CEO that wouldn’t just love to have that money kind of available, as opposed to, on the other hand, they really understand why we do it, and it’s not grudgingly that they do it.”

Many workers at Santa Rosa Memorial Hospital were cognizant of the Sisters’ good works within Sonoma County, where the hospital is located. Alexis remembered expressing worry that the hospital’s community service program would decline as the Sisters withdrew from Santa Rosa and the hospital faced new budget constraints. In response to her concern, one Sister told her, “Well, do you know of any other program [to close] that’s been developed and supervised by the Sisters?” Rebecca discussed the variety of community programs sponsored by St. Joseph Health System in the county each year, and how she was “astonished” at the amount of money they spent on “outreach programs, their dental program, all of this. Just a lot of money given to the poor and contributing to various things within the community. . . . And it’s wonderful what they do.” Yet she went on to describe the vacuum left by the Sisters as they withdrew from the administration of the hospital: “They’ve always been wonderful with regard for helping the poor. But they failed to see what was happening in their own house. They were all out in the community, [and] as this was deteriorating inside the hospital they didn’t see it.”

A medical administrator at the hospital put the point somewhat differently, speaking proudly of the hospital’s two mobile clinics, its dental clinic, and its array of programs for the poor:

There needs to be a profit or you can’t take care of anyone, let alone people who are unfunded or underfunded. The ministry of the St. Joseph Health System is very clear about improving the quality of life and the community that we serve, and is very clear about taking care of all comers.

In order to engage in these charitable works, the hospital had to be “tops in our game,” had to be “very frugal.” Whereas in a different era the religious mission of the hospital was front and center, this administrator implied, the hospital’s mission now required that the hospital succeed in the market. The mission and the market have become distinct from one another,

with the hospital's market success making possible a *separate* religious mission to the poor.

Of course there is another way to see the new relationship between the mission and the market, in that the espoused mission of the hospital may itself contribute to its bottom line. As Pete, a union organizer, pointed out, patients “want to feel that they’re more than just a number, [so] there’s definitely a value to having a religious brand on your hospital.” Its charitable works are also, in some ways, financially strategic. They assure the hospital’s reputation, allow it to claim not-for-profit tax exemptions, and make possible a significant fund-raising operation that complements its medical reimbursements from government and private insurers. Mobile dental clinics and an urgent care center in an indigent community, moreover, help to minimize costly emergency room visits by the poor and uninsured—visits that are still almost as high in number at Memorial as at the smaller former county facility. Is the horse of the mission driving the cart of the market, or the other way around? It depends on whom you ask.

From the Martyred Heart to the Mismatched Heart

Workers who have been at Santa Rosa Memorial Hospital for a decade or more have borne witness to changes affecting all of American medicine: new technologies, increasing government oversight, and new fiscal pressures to do more with less. All hospitals today must compete for the dollars that accompany patient utilization, and so all hospitals are compelled to engage in the same sorts of practices, including reducing the amount of charitable (free) care they provide, investing heavily in new technologies, increasing the provision of profitable services, negotiating more aggressively with insurance providers and physicians’ groups, and using staff more “efficiently.”³²

Simultaneously, however, many of the technological changes in medicine have actually enhanced workers’ capacity to care for their patients: new breathing machines have allowed respiratory therapists to help patients learn to breathe on their own; safer gasses and more sophisticated monitoring machines have allowed anesthesia technicians to feel more in control of patients’ pain; increasingly integrated computer systems have

decreased medical errors and increased workers' capacity to work together on behalf of patients. Other administrative and organizational changes may be disruptive but make intuitive sense, such as regulations that restrict employees' access to syringes and drugs; increasing oversight for regulatory agencies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and new attention to the patient's experience of and satisfaction with hospital care.

Yet while technological changes have in some ways made healthcare more effective, financial pressures have often eroded care in other ways. As a result of financial pressure to use hospital beds for only the most serious (and most lucrative) conditions, the patients who come to the hospital these days are sicker than they once were. Whereas a patient may have once come into the hospital with pneumonia and stayed for a week, Louise observed, patients today tend to "have multisystem problems." According to Rebecca, "because patients are sicker, you've got more order sets [for medications], more arrhythmias, more people coming in with weird things, you've got more sepsis, you've got more myocardial infarctions, and yet you're the person who remains doing your job." While George thanks new technology for helping him work in close coordination with his respiratory therapy patients, the same technology means that care is more time intensive and the "workload should adjust so that those things can be carried out." Alongside technological changes in medicine, the inpatient population has changed as well. Without changing staff arrangements, however, a sicker population means a slow but steady (and underrecognized) speedup among the staff of the hospital.

If anything, workers have felt the hospital move to *cut* staffing and reduce costs in ways that they feel sacrifice those vocational aspects of care they most enjoy. When Mari started working at Memorial as a nursing assistant in 1997 there were three assistants assigned for every twenty patients. Today, one nursing assistant must care for twenty patients on his or her own. Mari said,

The bottom line is that the individuals who pay this price are the patients, because if a patient waits five minutes for us to answer the call light to see what the patient needs, it's one thing. But if you wait fifteen, twenty minutes, it is not acceptable, and it happens, more and more and more. You

know, if you want a glass of water you can wait ten minutes. But if you really want to go to the bathroom you can't wait. Or if you're choking . . . sometimes we don't know.

These sorts of cuts mean that workers struggle to keep up with the most pressing medical needs of their patients, and are unable to tend to their spiritual or emotional needs. Susan spoke about how she was unable to do the “smaller things” that she liked to do for people. “As far as comforting somebody,” she said, she was often forced to rely on the hospital’s small volunteer staff. And while “the volunteers are amazing,” they just are not qualified to say things like “tell me about your cancer diagnosis now.” Mari explained how “compassion gets lost” because people feel stressed: “It’s more about liability now than [about how] the patient feels. You can cut corners anywhere as long as you make sure you don’t become liable.” As workers increasingly feel under pressure, they must cut out those aspects of care that are not measurable or medically justifiable. Louise lamented, “I’m an old nurse, I want everyone to have a bath in the morning, to get their teeth brushed, to get their hair brushed, to have fresh, cold water to drink before breakfast. And that’s not a possibility anymore.”

To add insult to injury, hospital management prohibits workers from discussing with patients what is going on with their other charges, meaning that they cannot tell their patients *why* they have been unable to meet their needs. Louise explained, “If I had a patient that was bleeding out and I had to hold their groin for twenty minutes, and then I went back into a patient’s room, [managers] don’t want you to tell them that you were busy doing something else.” Mari discussed how this restriction estranges workers from their patients: “What do the patients see? The patients see your face. They do not see management . . . And they look at me as cruel. Because they’re thinking, ‘Where were you?’ You’re not going to tell them, ‘I have 20 other people,’ because you don’t do that, you just don’t do that.”

Staffing shortages occasionally have led to more serious medical emergencies. As a respiratory therapist, George remembered getting called for a Code Blue on one side of the hospital, beginning to help a doctor insert a tube and manage the patient’s breathing, only to be called for another Code Blue in the pediatrics ward. The pediatric patient was a complicated case, and the doctor was confused enough about the reading on the patient to begin to remove the tube that George had inserted. George had to “grab his

hand” to stop him, and help the child to the helipad, where he was transported to nearby Oakland’s Children’s Hospital. George discussed how these kinds of incidents put his very professional identity at risk: “What if those things would have happened concurrently and I wasn’t able to give attention to one or another, and there was a sentinel event and there wasn’t a respiratory therapist? Whose license would have been in jeopardy? Not the hospital’s. *Moi*.” Rosanna, a medical interpreter, recalled a time when she was the only interpreter on duty and had been on lunch break when she saw a trauma helicopter landing. Having been scolded repeatedly for not clocking out during lunches, she decided to continue eating in her car. Upon return to the hospital the doctors in the Emergency Room were looking for her frantically, unable to speak with the parents of a Latino child who had been in an accident.

Staffing cuts have been accompanied by other sorts of changes that erode the quality of care workers feel able to provide. Jorge, a laboratory technician and phlebotomist, was upset when managers came into the hospital’s laboratory to tell him “we want you to use the bigger needles because they’re cheaper”; bigger needles allow phlebotomists to withdraw blood more quickly and “get to the next patient in line quicker.” He thought to himself, “Bigger needles? You’re only looking at a seventeen cents difference. At the end of the year you might save a couple of bucks, but that’s it.” He continued, “You’re going to make little kids suffer [a] twenty, sixteen, eighteen gauge needle.” The manager explained that since thicker needles would draw blood more quickly, there was less danger of blood clots, but Jorge felt that this medical justification for the change was dishonest. Frank discussed how managers were pushing for quicker turnover times between surgeries, meaning that workers were “cutting corners to do it.” Patients sometimes noticed: “I’ve had patients—I know this is bad—you lay them down on the bed and they’ve got those overhead lights that they put on, and they go, ‘Oh, look at the blood on the light!’ I don’t know how many times I’ve seen the [lights] hanging there just before the patient comes in and I’ve taken them away because somebody missed what they were doing because they were trying to move so fast.”

At the same time management has pushed workers in ways that compromise the work in which workers are invested, it has paid new attention to “customer satisfaction” measured by patient surveys. As a result, the

hospital has moved toward a regime of the “managed heart,” or more accurately the “*mis*managed heart.” Cynthia put the point succinctly: while administrators want workers to treat patients “like royalty as much as possible, the thing that is going to come into conflict with [that] is staffing, because I know that sometimes they’re staffing really low on the floors with aides. That’s a problem, because [aides are] mostly the people who would be the first responders to that kind of stuff.” The combination of cutbacks, on the one hand, and focus on the patient as a “satisfied customer,” on the other, has led managers to engage in the kind of emotional coaching that Arlie Hochschild observed in her study of airline attendants.³³ Betty was told that she did not smile enough. During one evaluation, after Rebecca had spoken with her supervisor about the level of stress she felt on her job, her supervisor suggested she create “stress-relieving goals” such as taking a vacation or getting a massage—ignoring the work-related causes of her stress. Susan learned to act as if she had time for patients even when she did not: “You can use your body language and make it feel like you have the time. . . . It’s not easy to, it’s a strain now.” After taking away resources employees felt were necessary to care for patients, managers coached workers to *act* invested in work from which they were increasingly alienated.

Workers at Santa Rosa Memorial Hospital are steeped in the history and values of the Sisters of St. Joseph of Orange during orientations and yearly evaluations, but for hospital management these values seem nearly indistinguishable from values applicable to any type of service work. When I attended an orientation for new volunteers at the hospital, a video on the Sisters’ history was followed immediately by a video entitled *The Simple Truths of Service* based on a book by the same name.³⁴ In the video, Johnny, a grocery bagger with Down Syndrome, starts putting handwritten “thoughts of the day” in customers’ bags, inspiring customers to come back to stand in his line. When the video finished, the trainer turned to the volunteers and said, “We want you all to be Johnny.” It seemed odd that a hospital, which must deal daily with patients’ vulnerability and uncertainty, would show a video situated in a grocery store. Since the practice of medicine has now become as impersonal as the grocery store, the implicit message seemed to be that the personal touch must now be produced intentionally.

It is unclear whether the focus on customer service—or even thinking of patients as “customers” at all—is in the best interests of patients

themselves. Workers discussed at length the steps the hospital had taken to give it the feel of a hotel. Most infamously, a former CEO decided to lay down expensive patterned carpet throughout the facility. “Now it’s all torn up because you can’t have carpet in a hospital,” Betty said. “Blood and piss and stains.” Others recalled how difficult it was to push beds across the carpeted floors. Eventually they replaced the carpet with equally expensive faux-wood laminate, which, Betty explained, was not much better: “First Center East had so much traffic within the first couple months that they started getting big bubbles in them. So they had to split them.” Dan, a radiology technologist, spoke of how the beautiful new laminated floors had already been replaced twice, and assumed the hospital would “have to go back to a more sensible flooring.”

Other examples of questionable expenditures abounded, from the expensive oak chairs in the cafeteria (nice for sitting, impossible to stack, and difficult for the Nutrition Service workers to move), to the elaborate sound-sensitive traffic lights (green, yellow, and red) that were installed in the hospital’s hallways as part of an initiative to keep the hospital quiet and alert workers when they were being too loud. Betty explained, “Every time I have to take a cart over to that east side I dread it. Those carts going over the threshold from the link to the hallway into the elevator, boom, bang, you know, there’s just no easy way to do it. They either need to come in and get all brand-name carts, or something [else], because I hate having to do that in the middle of the night.” Many of the bathrooms in the facility have hand-set, half-inch tiles that line the walls. When I spent time in the facility, the administration had recently decided to stop calling “Code Blues” over the hospital’s intercom, as one doctor explained, because patients do not like to think about death. This had led to some close calls among the medical staff, who were alerted to medical emergencies by beepers. Meanwhile, a treacly lullaby was broadcast over the intercom every time a baby was born—apparently because patients *do* feel happy at the thought of a newborn.

Workers expressed frustration at how decisions were made at the hospital as much as they did at any particular decision. Dan, a fifteen-year employee at the hospital, had seen four CEOs come and go, each of whom instituted new plans and policies without the involvement of workers, nurses, or even doctors. Louise noticed that “there’s always something new” in the hospital, and that while the administration used to “bring

[workers] into” discussions of changes, “now it’s just, ‘We had a committee we put together, we’ve decided you’re going to do this now.’” She attributed some of this change to new demands on supervisors: “They have nine million meetings management requires them to go to, and so it’s not their fault.” On three or four occasions Rebecca had offered advice to management about making her unit run more smoothly, only to be met with silence. The most frustrating time for her was when management had put together a committee to improve patients’ perceptions of the nursing staff. Rebecca had several ideas for improving these relationships, but was not acknowledged when she volunteered to serve on the committee. She soon realized that they “weren’t trying to get people’s opinions, [but rather] wanted to educate people” on the computerized evaluation system they had already decided to implement.

Increasingly, workers felt regarded as interchangeable parts. Frank discussed how stringent management had become about workers clocking in and out so as not to earn overtime. In a conversation with an anesthesiologist, the doctor said to Frank, “‘They want you to be robots.’” Frank agreed: “That’s exactly what they want. They want us to be robots. Just do what you’re told, and do it when they tell you and don’t think on your own. Don’t take any initiative.” This feeling was exacerbated when, in the early 1990s, the hospital sought to cross-train all service workers in doing the basics of patient care—something the hospital referred to as “patient-centered care.” The hospital fired all of its phlebotomists, with the idea that it would teach most service workers to draw blood and administer EKGs (electrocardiograms). Allison, a unit secretary, recalled being “way outside my comfort zone. I had been a paperwork person since day one, and I never imagined myself as a people person, let alone taking care of sick people.” Jorge remembered how two patients died as a result of amateur blood draws. In one instance, an employee had accidentally given the wrong blood to a trauma patient: “She was just crazy because she had thought she had killed this person. The person was dying at that point anyway. . . . But can you do that to a nineteen-year-old girl and then have her think that she had killed this person?” At that point the hospital reversed itself, rehiring specialized phlebotomists.

Workers’ feelings of exclusion from decision making was aggravated by the sense that financial decisions were consistently made at their expense. Workers are the first to be asked to reduce their hours when there are

fewer patients than usual. When the Sisters ran the hospital, workers were given annual Christmas bonuses. But in recent years hospital management had eliminated the bonuses, apparently using the same money to inspire frugality on the part of managers. A prevalent rumor among workers was that department managers who came in under budget were given half of the cost savings in bonuses. Jorge recalled: “We even had a phrase that we would kick out there during each quarter when [managers] get their bonuses: ‘Let’s see how many brand-new cars the supervisors and managers bring in on the days after.’” Frank thought that supervisors’ personal incentive to cut costs was at least partially responsible for their persistent emphasis on coming in under budget: “It’s cutting and lining their own pockets.”

Several workers were dismissive of the hospital administration’s attempts at regulating their emotional lives while, at the same time, they were committed to bringing “authentic” emotions to their patients. As Brandon, a lead SEIU organizer in the drive to unionize Santa Rosa Memorial Hospital, said, “Workers really believe in [the values espoused by the hospital], they really do, but they’ll say all the time, ‘We’re the ones who make these values real, not management.’” To some extent, then, workers seem to understand their “real” caring as a form of resistance—an assertion of values that the hospital leadership no longer truly supports. Of course, this sort of caring is one of the reasons that patients return to the hospital. On its own, then, this “resistance” only reinforces workers’ marginalization within the organization—the *misrecognized heart*.

Vacating the Vocation

In the mid-1990s, a small group of Sisters of St. Joseph of Orange approached Father Ray Decker, a retired priest, legal scholar, and friend of the order, with a request. The sisters were going to vote for a new mother superior, and one candidate had suggested that the order get out of the hospital business altogether. Could Father Decker write a white paper fleshing out the theological argument for abdication? The move would not have been unprecedented. The Sisters of St. Joseph of Carondelet, a sister order based in the Twin Cities in Minnesota, had sold their hospitals and then taken the proceeds and founded several free clinics.³⁵ According to

one union leader, these nuns believed that in the modern healthcare environment they could best live out their vocation by serving the poor.

In his white paper, Father Decker wrote that the mission of the Sisters of St. Joseph of Orange was “seriously jeopardized when the Congregation becomes so intermeshed and intertwined with governmental, medical and insurance institutions that it is serving more these systems than persons. The institutional restrictions now operative in the medical community make it impossible to serve the deeper calling which is to be identified with the ministry of Jesus . . . [and] to respond to the truly deeper spiritual needs of people.” This new institutional environment contrasted with the Sisters’ early history, he argued, in that earlier they had been able to “respond to [the medical and educational needs of people] simply and without needless complications,” as Jesus had “dealt immediately and directly with those who came to him for healing, solace, or compassion.” Moreover, he suggested, being entangled with the present-day medical system meant that “the survival of those institutions take precedence over the personal charisms [spiritual powers such as for healing] of its members, and in many cases even crushes those charismatic gifts for the sake of institutional survival.” Father Decker concluded that the order should “divest itself of those institutions which are part and parcel of the present medical care delivery systems over which it has no control, and re-invest its financial and personnel resources in supporting the various unique charisms of its individual members.” Father Decker’s advice was not heeded, and the Sisters continued to serve as the owners of St. Joseph Health System.³⁶

According to many workers, the values that the hospital publicly espouses have become little more than a patina of religiosity over an increasingly businesslike core. Frank said, with more than a hint of irony, “Everything’s push, push, push as far as making sure you charge the patient, making sure you’re not stockpiling, making sure that you’ve got the minimum you need for the time. They always are watching you and pushing you about that, and they call it *‘being a good steward.’* There’s no spiritualism in it at all. It’s just sterile.” José, a practicing Catholic, suggested the “values that they’re preaching go to garbage” in management’s daily practices. Dan assumed that the “suits are hiding behind these values. They’re espousing them all the time and it strikes such a phony cord.”

In the hospital’s annual employee evaluations, workers are asked to discuss the ways they and their co-workers have lived out the values of the

hospital. Interestingly, while the values publicly espoused by the hospital are “Dignity, Excellence, Service, and Justice,” justice is excluded from the list in these evaluations. Moreover, each of the other values is interpreted in ways that are consistent with managerial priorities:

Adaptability—Service

- Seeks to understand and responds to changing individual or team priorities.
- Accepts and deals with changes positively.
- Accepts direction willingly in order to adapt his/her role to organization or team change.
- Supports team and organizational leaders in change implementation.

Communication—Dignity

- Smiles and greets others. Communicates in a respectful manner.
- Listens attentively to others to understand what is being said.
- Initiates difficult or uncomfortable conversations including requests for personal feedback.
- Discusses private matters in a private area.

Continuous Improvement—Excellence

- Champions/supports efforts that boost the organization’s overall efficiency and quality.
- Seeks help in understanding and incorporating SJHS best practices and continuous improvement philosophy.
- Uses experience, knowledge, and data to make informed decisions.
- Adapts to changing needs by acquiring new skills, knowledge, and behaviors.

Customer/Patient Focus—Service

- Attends to individuals needing assistance by saying “I will help you find out,” rather than “I don’t know” or “That’s not my job.”
- Seeks to understand and exceed customers’ service expectations by creating an environment characterized by hospitality, trust, and a spirit of community.
- Makes response to patients and others served a priority.
- Seeks to provide assistance that respects cultural health beliefs and practices.

Supervisors then rank employees on a scale from one (below expectations) to four (exceeds expectations) in relation to these values. Several employees discussed the ways that the process seemed designed to discourage them. Dan referred to the evaluations as “intellectual purgatory,” and suggested that his manager deliberately gave people low marks. If “everything’s going smoothly,” he observed, workers get a two out of four, “and you got to walk on water to get a four, so nobody generally gets fours.” Since the evaluations are not tied to worker pay, Dan continued, “You’d think this would be used as a morale-building exercise.” Instead, it seems, the evaluations were used in this department as a sort of annual repentance, a way for supervisors to demonstrate how workers might live out the hospital’s values more observantly. Rosanna once overheard an administrator speaking with her supervisor about not giving high evaluations to employees because it might lead employees to ask for raises. A charge nurse admitted: “The joke is that you never hear of anything you do good, ever. And that is true.”

At the same time, the small and symbolic ways that the hospital had once reinforced its values in daily practice were gradually eliminated. The hospital got rid of the Hawaiian vacation they once had given workers who had been at the hospital for fifteen years. The annual Christmas party was cancelled, as was the summer picnic barbecue. Workers were no longer given gift certificates to buy turkeys at Thanksgiving. Employees used to get a crate of oranges for St. Joseph’s Day, but now they get bookmarks. Where workers were once given free meals on their birthdays, they are no longer given anything. The content of these perks were less important than their symbolic value as expressions of the Sisters’ care for workers. Martha, a medical transcriptionist who had worked at the hospital for eighteen years, was laid off in 2007 after the hospital outsourced its transcription to a company in Colorado. Although she was disappointed at being forced to leave, it was the silence accompanying her departure that got under her skin. She worked from home, so her years at Memorial ended with a mouse click.

Workers were frustrated that the structure of work made the practice of the hospital’s values impossible. Frank felt compelled to take a position elsewhere after working at Memorial for many years:

It gets to the point where, you know, you just don’t want to do less anymore. You don’t want to compromise your patients anymore. You’ve been at this

home for seventeen years, and you gotta say good-bye. Because in your heart you can't tolerate that. And you won't be part of it. So you leave. You have no other recourse. If you [stay], you're less of a person, you have no integrity. You have to leave because it's just not tolerable anymore. I can't accept any less, that's not why I got into this business to take care of people. You don't compromise that.

Many workers have stories of co-workers, supervisors, or doctors who got fed up with the hospital. Alexis recounted how the head of the physical therapy department had resigned after the administration forced him to lay off his best supervisors. Jorge recalled how doctors were leaving Memorial for the other area hospitals. George remembered how, in the face of short staffing, "a lot of people left because they didn't want to work in that kind of environment."