The Approved Miracle of Saint Elizabeth Ann Seton*

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Abstract

Saint Elizabeth Ann Seton (1774–1821) was a convert to Roman Catholicism and foundress of the Sisters of Charity, the first sisterhood native to the United States. She is also the first person born in the United States to be canonized a saint. The second of three cures attributed to the intercession of Mother Seton was of Anne Theresa O'Neill. Anne was born at Baltimore in 1947 and, at the age of four, was diagnosed with acute lymphocytic leukemia at St. Agnes Hospital, Baltimore, Maryland. At the time, acute leukemia, like other aggressive malignancies, was considered a fatal disease without any treatment that assured a cure. In essence, no effective therapy for disease control and sustained remission existed. Anne's cure, which was considered acceptable by the Sacred Congregation of Rights in 1959, would contribute directly toward Mother Seton's beatification and ultimate canonization on September 14, 1975, out-

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side Saint Peter's Basilica in Rome by Pope Paul VI. Ms. O'Neill attended both the beatification as a thirteen-year-old girl and the canonization ceremony at age twenty-seven, as a mother of several children and accompanied by her mother and husband.

Introduction

Yes, Venerable Brothers and beloved sons and daughters! Elizabeth Ann Seton is a saint! We rejoice and we are deeply moved that our apostolic ministry authorizes us to make this solemn declaration before all of you here present, before the holy Catholic Church, before our other Christian brethren in the world, before the entire American people, and before all humanity. Elizabeth Ann Bayley Seton is a saint! She is the first daughter of the United States of America to be glorified with this incomparable attribute! . . . Saint Elizabeth Ann Seton is an American. All of us say this with spiritual joy, and with the intention of honoring the land and nation from which she marvelously sprang forth as the first flower in the calendar of the saints.

Rejoice, we say to the great nation of the United States of America. Rejoice for your glorious daughter. Be proud of her. And know how to preserve her fruitful heritage. . . . We are pleased to note that this event coincides with an initiative of the United Nations: International Women's Year. This program aims at promoting an awareness of the obligation incumbent on all to recognize the true role of women in the world and to contribute to their authentic advancement in society . . . finally we must recall that the most notable characteristic of our saint is the fact that she was . . . the foundress of the first Religious Congregation of women in the United States.¹

Biography

Saint Elizabeth Ann Seton (August 28, 1774–January 4, 1821) was born in New York of prominent British and French ancestry. The Bayley and Charlton families were among the earliest colonial settlers of the New York area. Following the death of her mother, her physician father, Dr. Bayley, married Charlotte Amelia Barclay, but they were later separated.

Elizabeth and her sister were rejected by their stepmother. Elizabeth had a natural bent toward contemplation and was given toward introspection. She would eventually wed William Magee Seton, witnessed by Samuel Provost, the first Episcopal bishop of New York. William Magee was educated in England and was a founding partner in the import-export mercantile firm that would eventually come to be known as Seton, Maitland, and Company in 1793. Socially prominent in New York, the Setons belonged to the fashionable Trinity Episcopal Church. Elizabeth was a devout communicant there.

She and William Magee were happily married and had five children. They would ultimately experience financial problems, and her husband began to show evidence of tuberculosis. To restore her husband's health, Elizabeth, William, and their eldest daughter Anna Maria made a sea voyage (1803) to the warm climate of Italy. While there, William died in December, leaving Elizabeth a widow at age twenty-nine, with five young children. The Filicchi (Antonio and Amabilia) family, friends of the Setons through the former business, provided hospitality to the widow and child until the Setons returned home the next spring. They introduced Elizabeth to Roman Catholicism. Antonio, who had business interests in America, accompanied the Setons back to America and instructed Elizabeth in the faith.

Upon returning to the United States, Elizabeth's religious inclinations incurred the ire of both family and friends. While discerning God's will for her future, Elizabeth turned to the Virgin Mary as her prism of faith. After wrestling with doubts and fears in her search for truth, she resolved her inner conflict regarding religious conversion and embraced the Roman Catholic faith. She was received at Saint Peter's Church in lower Manhattan on March 14, 1805. She received her First Communion later on March 25. She was confirmed by her spiritual father Bishop John Carroll (1735–1815) the next year on Pentecost Sunday.

Elizabeth providentially met Rev. Louis William Dubourg, S.S. (1766–1833), who was visiting New York. He desired a congregation of religious women to teach girls in Baltimore. With Bishop Carroll's concurrence, he invited her to Baltimore with the assurance that the Sulpicians would assist her in forming a plan of life that would be in the best interests of her children. They wished to form a small school for religious education of children. After serving as a school mistress in Baltimore, Elizabeth was recruited along with six other women by the Sulpicians to form a sisterhood modeled on the Daughters of Charity of Paris (founded 1633). Only Elizabeth pronounced vows of chastity and obedience to then-Archbishop Carroll in the lower chapel of Saint Mary's Seminary. He gave her the title "Mother Seton."

A wealthy seminarian and convert, Samuel Sutherland Cooper (1769–1843), purchased 269 acres of land for the establishment of her sisterhood, near Emmitsburg, Maryland. He also wished to establish an institution for the education of females and character formation rooted in Christian values and the Catholic faith. Elizabeth opened Saint Joseph's Free School on February 22, 1810, to educate needy girls in the area; it was the first free Catholic school for girls staffed by sisters in the country.

Elizabeth was elected by the members of her community to be the first Mother of the Sisters of Charity, and she was reelected successively and remained at its head until her death. On September 14, 1975, she was canonized outside St. Peter's Basilica in Rome by Pope Paul VI, the first native born of the United States to be raised to sainthood.

The Miracle²

Anne Theresa O'Neill was born at Baltimore on October 7, 1947, to William Richard O'Neill and Felixena Phelps O'Neill. Until the early part of 1952, she enjoyed good health. With the appearance of ecchymotic lesions on her neck, her parents took her to her family physician, Dr. E.W. Johnson. His history and physical examination dated February 17, 1952, is as follows:

History

This four-year-old white female is admitted with history of recent paleness, irritability, glands in neck. Patient was advised to have blood work done and was found to have a leucocytosis and secondary anemia. Advised hospital. About a year ago child had an allergic episode marked by urticaria and angioneurotic edema. Temperature elevated recently.

PHx: Non contrib.

FHx: Ca. on maternal side. Also heart disease.

1 Sibling

No history of blood dyscrasis.

Physical

Child is pale, irritable, W.F. No apparent distress. Head normal. EENT Pupils normal. Conjunctivae pale. Also gums, tongue, and MM. Septum midline.

Neck: Many sizable discrete nodules in cervical lymph gland system. Fairly hard nodules and apparently painful.

Resp: Lungs clear. Discrete axillary lymphadenopathy.

C-V: heart sounds normal. No murmur noted.

ABD: Soft, non-tender. Adenopathy. L&K not felt. Spleen easily felt.

Extrem: Many ecchymosis of the legs.

IMP: Leukemia.

A complete blood count (CBC) was ordered and demonstrated anemia. The following day (February 17, 1952), she was admitted to St. Agnes Hospital and diagnosed with acute lymphocytic leukemia.

In a short time, a number of symptoms consistent with this malignancy would appear. She was pale and lethargic and developed cervical lymphadenopathy. A bone marrow aspirate on February 18, 1952, confirmed acute lymphoblastic leukemia. She would receive numerous transfusions and medications. These efforts appeared to be futile. Her physician advised her mother that there was no longer anything that they could do for her. A letter written on March 12, 1952, from medical resident John C. Healy, M.D. (St. Agnes Hospital), to Dr. Sacks indicates, in part,

This four-year-old white female . . . was advised to have blood studies done and which were later done at this hospital where a hemoglobin of 34 percent t5.2 grams; red count of 2,040,000—and a white count of 7,250 was found: The differential revealed two non-filament polymorphonuclear cells; 98 percent peculiarities in the lymphocytes; However, a bone marrow was performed and shoed a typical picture of acute lymphatic leukemia.

The platelet count at this time was 64,000 and the child was extremely purpuric. She ran a temperature varying from 99 to 102 degrees daily while in the hospital and was admitted to this hospital on February 17. The patient was transfused with 200 cc. of fresh whole blood on the 18 February, and 250 cc. on the 19 and 20 February.

The marrow smear was read on the 21 February and on the 22 February the patient was started on 25 milligrams of Cortone q. four hours. She was also started on Rutorbin caps. 300/60 v. day. The patient was given crystocillin 300,000 units q. day and this regime was continued to the time of her discharge on the 28 February 1952.

Dr. Milton S. Sachs, a specialist in hematology, pathology, and medicine, of the University of Maryland Hospital, then one of the foremost authorities on leukemia, was consulted. He affirmed that in his experience spontaneous remissions happened in one percent or less of cases presented to him.

He recommended that Anne Theresa be transferred to the university hospital to be treated with a new drug, aminopterin. The transfer occurred on February 28, 1952. Under the treatment, Anne Theresa grew worse. Over the course of three weeks, she developed facial edema, and her suffering intensified. Her case at this point was considered hopeless, and she was discharged from the hospital on March 27, 1952.

Dr. Sachs continued, however, to personally follow her. After being home for three days, Dr. Sachs rushed her to the university hospital again for a blood transfusion. He remarked, “we can either try once more or give up.” After the transfusion, her parents took her home against the doctor’s wishes. Within two weeks, she developed numerous ulcers diffusely, high fever, and gave off putrid odors. Nutritionally, she could tolerate sips of Coca-Cola. She developed a chicken pox super-infection, which Dr. Sachs reported was a severe case.

During Holy Week, her breathing had become labored and by all signs the end was near. On April 9, Dr. Johnson rushed her back to St. Agnes Hospital to place her in an oxygen tent. An interval note dated April 9, 1952, by Dr. Leo Ley Jr. (St. Agnes Hospital), reads, in part,

Interval Note

This four-year-old girl was discharged from this hospital about five to six weeks ago with a diagnosis of leukemia. Since that time the child has steadily failed, and the physical condition of the girl has

gotten worse. The child has become lethargic and quite apprehensive. Patient is still difficult to manage. Readmitted for evaluation.

Physical

This child is quite lethargic, but cries on being examined. There is no dyspnea, cyanosis, or edema. The skin of the entire body is covered with innumerable lesions of multiforms. Some are encrusted, others popular on an erythematous base, others ulcerous, others macular, and various combinations. The child resists oral examination but erythematous streaks and patches are seen. The liver is enlarged, and the spleen is not felt specifically. Heart is normal. Breath sounds normal, but slightly bronchial. Remainder of examination unchanged.

IMP: Leukemia advanced.

Her breathing improved on arrival, so the tent was not necessary. Anne's mother and father were told by the doctors that she would last only about two weeks. Anne Theresa was in pitiful condition. She was pale, irritable, and weak; and her face was edematous. She could neither sit nor stand. The diagnosis this time was "advanced leukemia."

Sr. Mary Alice Fowler was supervisor of St. Louise's Children's Ward in St. Agnes Hospital. As she passed Anne's bed one day, she recalled the great favor Mother Seton obtained for one of her patients who had sarcoma of the humerus. Sr. Mary Alice always had a deep personal devotion to Mother Seton and felt that this would be a good case for her to show her power with God. Mrs. O'Neill was a woman of great faith and prepared to do anything to help save her daughter, so Sr. Mary Alice gave her many prayers to ask Seton's intercession and told her to distribute the prayers to her relatives and friends. Mrs. O'Neill pledged cooperation.³

A relic, a cloth touched to Mother Seton's remains, was pinned to the child's gown.⁴ A novena was started; and during the novena, Anne Theresa seemed to demonstrate signs of improvement. She began to sit up and eat. Within a few days she was allowed up and walking. Anne continued to improve and, on April 27, 1952, was discharged.

Her hematologic profile (i.e., peripheral smear, CBC) and peripheral was good. The day of discharge, she was taken by her parents to Emmitsburg to visit Mother Seton's tomb. On July 6, 1954, and October 20, 1954, blood smears at St. Agnes Hospital were read as normal. On January 7, 1956, a follow-up bone marrow aspirate analyzed by Dr. Thomas Crahan (pathologist at St. Agnes Hospital) was read: "essentially normal marrow." Again on March 12, 1957, just five years after sickness, Anne O'Neill submitted to another bone marrow aspirate for the purposes of an article. The report again was normal as read by Dr. Sachs.

It was while a student at Seton High School that Anne attended the beatification ceremony in Rome. There, she was singled out by the late

Pope John XXIII, who blessed her. "This, I think, was the happiest moment of my life. . . . I was so thrilled. I think Pope John was a saint."⁵

In September 2000, Anne, then fifty-three years of age, a retired hairdresser and a grandmother, was interviewed during the twenty-fifth anniversary year of the canonization and recalls

the house where Mother Seton died. They put me inside the ropes that block off her room. I felt a good feeling, the presence of Our Lord and Mother Seton together. . . . (The miracle) . . . it's just part of my life. It makes me firmer in my faith. It was a personal gift from God, but my mom was the key part. I was just the little person that got healed.⁶

Discussion on Acute Lymphoblastic Leukemia

The leukemias, cancers involving the hematopoietic system, are recognized as the most frequently observed malignancies in childhood; and among them, acute lymphoblastic leukemia is the most common. The majority of patients with acute lymphoblastic leukemia also present in early childhood.

Acute leukemia, like other aggressive malignancies, is considered a fatal disease without treatment; and treatment itself does not assure cure. Leukemia develops in the bone marrow—the central organ of hematopoiesis—as an expanding clone, in this case of lymphoid cell origin, overwhelming production of all normal blood cell lines. Consequently patients are predisposed to unusual bruising/purpura and risk of bleeding associated with thrombocytopenia and significant to severe infections associated with evolving neutropenia, as well as complications of severe anemia that may be visibly recognizable as pallor. Patients may present with any one or a combination of these complications along with more general complaints such as fever, fatigue, malaise, and pain. Physical examination frequently reveals some bulky disease in form of lymphadenopathy and/or hepatosplenomegaly. These observations were made in the case of the young girl described here.

A review of the medical literature of the early to mid-twentieth century reveals clear descriptions of leukemia in childhood with observations of differences between aplastic anemia and apparent lymphoid and myeloid leukemia presentations, as well as acute and chronic forms. Bone marrow aspirations were also increasingly being done to confirm and classify disease.⁷ Although no national cancer monitoring program existed then, case series and large hospital disease registry programs cited cancer as the third leading cause of mortality in children three to fourteen years of age and the leading cause of mortality from disease in that same group. Leukemia was the most common of the malignancies, with acute lymphoid leukemia more common in children than adults.⁸ These observations in the U.S., as well as other developed countries, still hold true today.

In the case's described time period, no effective therapy for disease control and sustained remission existed; medical case reports of spontaneous remissions describe essentially waxing and waning manifestations of disease with ultimate recurrence and patient demise due to leukemia complications, usually in a matter of weeks to months from presentation, rarely surviving two years regardless of interventions employed.⁹ Care was essentially supportive, with transfusion of blood products as available, treatment of infections with available antibiotics, and comfort measures or symptom relief with common remedies of the time. Radiation therapy might also be applied to bulky disease with varied response but with only temporizing benefit at most. Dr. Sydney Farber's publication in 1948 of the effects of the folate antagonist aminopterin on acute leukemia heralded the advent of rational chemotherapy investigation and application in pediatric leukemia and pediatric oncology in general. Treatment clearly induced response and extended lives for several more weeks in many, but toxicities were also evident.¹⁰

The 1950s saw more application of aminopterin therapy along with introduction of steroid therapy—initially cortisone and then newer oral preparations of more potent glucocorticoid prednisone. Purine analogs, such as 6-mercaptopurine, were also introduced. Such treatments were documented to induce remissions and palliate symptoms in many for several weeks and even months; however, relapses occurred in all.¹¹ Other therapies that proved less effective for acute leukemia were also tried.¹²

There appear no survivors with documented medical cure of leukemia with therapies employed in this time period.

Promising anti-leukemic agents, such as vincristine and l-asparaginase, would follow, but it was not until the late 1970s and 1980s, with introduction of extended regimens of multiagent chemotherapy, as well as treatment of central nervous system disease—or central nervous system prophylaxis if central nervous system disease was not evident at diagnosis—that progress in treating disease and sustaining disease remission offered significant likelihood of cure for many with childhood acute lymphoblastic leukemia. Entering the twenty-first century—fifty years beyond this case presentation—major advances have been seen in treating childhood leukemia and cancers in general. These advances have led to current long-term, disease-free survival projections of greater than 80 percent in childhood acute lymphoblastic leukemia and, in best risk subsets, greater than 90 percent. The current state of science, however, indicates that all children with acute lymphoblastic leukemia require multiagent chemotherapy and central nervous system treatment/prophylaxis to be offered any hope of medical cure of disease.¹³

Concluding Remarks

The evil of sin, which manifests as illness and suffering, has afflicted mankind since time immemorial. Jesus often displays compas-

sion for humanity by healing others, and there are times when he allows himself to be moved by the prayers and supplications of others to heal. Recall the faith of the friends of the paralytic (Lk 5:17–26), which moved Jesus to heal him and forgive his sins. There are also times when Jesus makes use of mankind through their God-given intellects and the science of medicine to heal others. This is evident in numerous cures due to the wonders of modern medicine of ailments once felt to be incurable.

Modern medical discoveries have allowed us to advance in our understanding of the mechanism of disease. Yet it was not until the late 1970s and 1980s that progress in treating this form of leukemia was made. In the 1950s, at a time when a durable cure was not known for acute lymphoblastic leukemia, God allowed himself to be moved by the prayers and supplications of members of the Church Militant and his servant, Elizabeth Seton, to heal a little girl. The saint-making process of the Roman Catholic Church makes provision for a healthy respect between the physician and the theologian, and the process cannot advance without physicians' input. Simply put, this process makes evident God's ongoing interaction with creation, and for this, we are grateful.

Notes

¹ Pope Paul VI, homily at the canonization of Elizabeth Ann Seton, September 14, 1975.

² Taken from the archives of the Daughters of Charity at St. Joseph's Provincial House in Emmitsburg, Maryland.

³ Sister Mary Alice Fowler, signed statement, November 20, 1959.

⁴ Sister Mary Augustine, D.C., "Where Are They Now," *Seton Causeway*, December 1973.

⁵ Ibid.

⁶ Jane Honigs, "The Road to Sainthood: Maryland Woman Recalls Her Miracle," *Record Herald* (Waynesboro), September 14, 2000.

⁷ A.H. Washburn, "Lymphatic Leukemia with Leukopenia in Young Children," *American Journal of Diseases of Children* 129 (1925): 631–640; P. Sturgeon, "Idiopathic Aplastic Anemia in Children: Its Early Differentiation from Aleukemic Leukemia by Bone Marrow Aspiration," *Pediatrics* 8 (1951): 216–226.

⁸ J.V. Cooke, "Acute Leukemia in Children," *Journal of the American Medical Association* 101 (1933): 432–435; J.V. Cooke, "The Incidence of Acute Leukemia in Children," *Journal of the American Medical Association* 119 (1942): 547–550; H.W. Dargeon, "Cancer in Children from Birth to Fourteen Years of Age," *Journal of the American Medical Association* 136 (1948): 459–468; J. Arey, "Advances in the Control of Cancer in Infants and Children," *Journal of Pediatrics* 54 (1959): 406–408.

⁹ E.A. Moody and R.W. Davis, "Duration of Acute Leukemia in Children—Review of the Literature and Report of a Case of Unusually Long Survival," *American Journal of Diseases of Children* 80 (1950): 955–962.

¹⁰ S. Leikin et al., “The Treatment of Acute Leukemia in Children,” *Journal of Pediatrics* 41 (1952): 40–46; S. Farber et al., “Temporary Remissions in Acute Leukemia in Children Produced by Folic Acid Antagonist, 4-Aminopteroylglutamic Acid (Aminopterin),” *New England Journal of Medicine* 238 (1948): 787–793; S.D. Mills, J.M. Stickney, and A. Hagedorn, “Observations on Acute Leukemia in Children Treated with 4-Aminopteroylglutamic Acid,” *Pediatrics* 5 (1950): 52–56.

¹¹ C.B. Hyman and P. Sturgeon, “Prednisone Therapy of Acute Lymphatic Leukemia in Children,” *Cancer* 9 (1956): 965–970.

¹² N.J. Smith, S. Rosello, and H. Shay, “The Effect of Triethylene Thiophosphoramidate in the Treatment of Leukemia and Certain Lymphomas in Infants and Children,” *Journal of Pediatrics* 46 (1955): 493–505.

¹³ H.A. Pearson, “History of Pediatric Hematology Oncology,” *Pediatric Research* 52 (2002): 979–992; T.M. Horton and C.P. Steuber, “Overview of the Outcome of Acute Lymphoblastic Leukemia in Children,” *UpToDate* (2011), http://www.uptodate.com/contents/overview-of-the-outcome-of-acute-lymphoblastic-leukemia-in-children?source=search_result&search=Overview+of+the+Outcome+of+Acute+Lymphoblastic+Leukemia+in+Children&selectedTitle=1~150.