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Nursing with a Message

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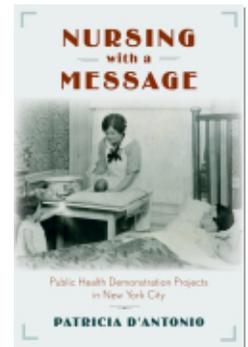
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Introduction

On March 10, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). Seven months later a key feature of the bill, the Center for Medicare and Medicaid Innovation (Innovation Center), opened its doors. While the ACA looks to restructure key features of the US healthcare payment systems, the Innovation Center serves as an incubator of new ideas to deliver and pay for care that will improve quality and decrease costs. To this end, its \$10 billion budget sets in motion demonstration projects to increase access to high-quality, cost-effective, and coordinated healthcare for beneficiaries of Medicare, Medicaid, and state children’s health insurance programs. Its charge is to rigorously and rapidly assess the progress of these demonstrations, and to replicate those with a “high return on investment” in communities across the country. Its first initiative, Strong Start for Mothers and Newborns, has now funded 182 demonstration projects to improve the health of mothers and babies. The intent is that the more successful of these demonstrations can be scaled up to national initiatives that will reduce early elective deliveries, decrease preterm births, test new approaches to prenatal care, and improve outcomes for mothers and babies.¹

The Center for Medicare and Medicaid Services (CMS) has a thirty-year history of supporting such demonstration projects, most recently in value-based payment systems and disease management and care coordination.² Yet demonstration projects in healthcare in the United States predate the CMS’s initiatives. *Nursing with a Message* examines the history of the first such demonstration projects in New York City in the 1920s and 1930s, a period commonly referred to as the interwar years. Surprisingly, historians have yet to look systematically

at these health demonstration projects that were testing new models of health-care delivery in selected urban and rural communities throughout the country. The brief accounts that do exist are embedded in the histories of the foundations and philanthropies that supported the projects or in the histories of city and state public health departments that looked to them for their policy and practice implications.³ The East Harlem Nursing and Health Demonstration Project, one of New York City's signature demonstration projects, has had some recognition for its seeming success in settling long-simmering debates about the best organizational structure for public as well as private public health nursing.⁴ But this book approaches these demonstrations in New York City as they relate to each other rather than, as in prior work, in isolation.

We need to do this for two reasons. First, there exists an entrenched, yet erroneous, belief that public health prevention and treatment services had their roots in the community health movement of the 1960s. Second, and even more significantly, the United States stands ready to commit significant resources to bolster and expand the capacity of community health centers to provide comprehensive, high-quality, and coordinated care that will target health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved neighborhoods. It is as committed—as in the past—to identifying and using key quality improvement data to disseminate best practice models to hospitals and healthcare systems throughout the country.⁵ It is urgent that we understand the history of an earlier movement also committed to access, quality, care coordination, and data to more fully understand all the possibilities and the problems of a national agenda rooted in the needs of particular families and communities.

Three threads, mirroring those of other health demonstration projects throughout the country, ran through all of New York City's projects. The first involved a commitment to broaden public health initiatives to pregnant women and preschool children. These populations had been overlooked in the prewar emphasis on infants and school-aged children. Yet, both mothers and their very young children had, as so many do today, appalling rates of morbidity and mortality. The second centered on initiatives that would teach individuals and families to demand health as well as illness care from their own private physician or, if unable to afford such medical care, from publicly funded clinics. The third was the central place of the public health nurse as the agent who would deliver these messages in her daily rounds in neighborhoods and homes. This last thread seemed self-evident. Public health nurses had long considered themselves and had been considered by others as the "connecting link"—between patients and physicians, between and among

institutions, and between scientific knowledge and its implementation in the homes they visited. But the nurses in New York City's demonstration projects, like progressive urban colleagues throughout the country, went one step further. They used their experiences in the three demonstration projects to work toward identifying the whole families of their mothers and preschool children as their practice domain.

As historians have long argued, these nurses worked within the interwar years' new constellation of ideas, practices, actions, and actors that shifted the structure of initiatives that might improve the health of women and children in particular, and that of the public in general. The quest to infuse "science" and "scientific meaning" into reasoned, scholarly investigations and also into everyday practices created a new "science of childhood" that emphasized careful developmental studies, on the one hand, and a renewed drive to translate the implications of these results to those individual mothers most responsible for rearing a new generation of upstanding citizens, on the other. Historian Rima Apple's construction of the idea of "scientific motherhood" captures perhaps the strongest impulse to teach mothers the latest science behind such issues as proper prenatal care, infant feeding, and the psychological and environmental requirements to ensure their children's normal growth and development. This impulse, Apple argues, constructed mothers as dependent and passive learners from expert physicians, psychologists, nutritionists, and nurses. But even if believed to be dependent and passive, such mothers were, in fact, quite eager consumers of the literature, lectures, well-baby clinics, and individual conferences that came to large cities and small rural hamlets throughout the country in the 1920s.⁶ Most financial support for these came from the unwieldy titled federal legislation, the "Promotion of the Welfare and Hygiene of Maternity and Infancy Act," passed in 1921, that quickly became more popularly known as the "Sheppard-Towner Act" in honor of its legislative sponsors. And while Sheppard-Towner monies did not provide any direct support in New York City's health demonstration projects, it did place nurses in a very direct role in implementing what historians Barbara Beatty, Emily Cahan, and Julie Grant have described as an "empire of child services" created through the 1920s.⁷

This same quest also created a new impulse to, in historian Jodi Vandenberg-Daves's words, "medicalize the maternal body" itself.⁸ The timeless debate about whether the process of childbirth required patient watching and waiting as part of a normal experience shared by women across generations or if it needed active and expert intervention by specially trained physicians tipped in the 1920s in favor of skilled medical attendance. Historian Jacqueline Wolfe locates this change in the introduction of obstetrical anesthesia to the

birthing process, a change that predated but certainly supported the accelerating 1920s movement to move births from homes into hospitals.⁹ And the quest also medicalized—or psychologized—a new framing of how to think about the misbehaviors of children and, especially, adolescents. Historian Kathleen Jones’s work on the origins of the “child guidance” movement in the 1920s extended an emphasis on the “whole child” to include his or her emotional as well as physical and developmental life.¹⁰

Nursing with a Message places New York City’s nurses in the middle of this turn toward science. It centers on the power of nurses—too often invisible in histories of healthcare—to also shape the public health messages of the interwar years. These nurses do provide a different lens with which to view this turn: in their day-to-day work with individuals, families, and communities they had to make their own decisions about what aspects of science seemed most relevant, at any one point in time and over the longer time frame within which they envisioned their work. This book draws on Steven Luke’s understanding of power as dispositional—that is, it focuses on what these women believed to be their capacity to influence both those they worked for and those they served. The nurses in New York City’s health demonstration projects truly occupied a place in the “middle” of the goals of public health reformers, physicians, and patients, and this study shows how they strategically navigated often-rocky shoals. It foregrounds the ideas, the practices, and the effects of the work of these public health nurses as they negotiated their roles within this matrix of competing agendas.

On a broader level, *Nursing with a Message* explores the day-to-day processes involved in the coming together and moving apart of different organizations, disciplinary interests, knowledge domains, and spheres of public and private responsibilities involved in caring for those in need at the point of delivery of service. More specifically, it uses the public health nurses involved in New York City health demonstration projects in the 1920s and the 1930s as a case study of disciplinary tensions inherent in projects with various constituents and invested in multiple and sometimes contradictory outcomes. It shows how one central public health discipline searched for better ways to care for the people it served even as it attended to its own advancement, place, and power in a very complicated space of ideas, practice, action, and actors.

Nursing with a Message centers on three seminal health demonstration projects in New York City in the 1920s and 1930s. Most of its analysis focuses on the East Harlem Nursing and Health Demonstration Project, reconstituted as the East Harlem Nursing and Health Service in 1928. This particular demonstration and later nursing service was completely managed by its public health

Table 1. Key Features and Funders of the Health Demonstration Projects and Health Clinics in Manhattan

<i>Demonstration</i>	<i>Purpose</i>	<i>Funder</i>	<i>Dates</i>
East Harlem Health Demonstration Project	<p><i>Care Coordination:</i> To bring all the neighborhood’s health and welfare agencies together in one building for “one-stop shopping” Total of 22 health and social welfare agencies involved Each maintained own budget, administrative structures, and client base <i>Intent:</i> To “demonstrate” increased service utilization when more accessible; to “demonstrate” feasibility of coordinated neighborhood services; to test premise that physical proximity would eliminate costly service duplication and deliver better health outcomes <i>Organizational Structure:</i> Lay health officer presiding over a Community Health Council made up of participating organizations <i>Goal:</i> To lay groundwork for a coordinated system of neighborhood health centers that would better integrate the work of private and public health agencies to provide a more seamless experience for individuals and families</p>	Rockefeller Foundation	1921–1932
East Harlem Nursing and Health Demonstration	<p><i>Care Control:</i> Unlike “care coordination” in which individual public and private agencies would maintain control over their own governance and budget, this demonstration in “care control” would pool the personnel and the financial resources of the agencies that provided nursing services to the families of East Harlem—the Henry Street VNS (that provided bedside nursing to the sick in their homes), the AICP (that provided tuberculosis nursing), the Maternal Center Association (that provided prenatal and home birth services), and the Department of Health’s nurses (that provided school nursing and well-baby care)—into one controlling organization with its own budget <i>Intent:</i> To “demonstrate” the possibility of more efficient use of nursing services; to research the best organization of nursing services; to decrease maternal and infant mortality; to use efficiencies to expand nursing services to preschool children <i>Organizational Structure:</i> Independent director of nursing and governing board <i>Goals:</i> To lay research groundwork for generalized nursing services as the hallmark of public health nursing practice; to perform service and research</p>	Rockefeller Foundation	1922–1928

(continued)

Table 1. Key Features and Funders of the Health Demonstration Projects and Health Clinics in Manhattan (Continued)

<i>Demonstration</i>	<i>Purpose</i>	<i>Funder</i>	<i>Dates</i>
Bellevue-Yorkville Health Demonstration Project	<p><i>Administrative Partnership with the Department of Health Intent:</i> To increase the taxpaying public's willingness to pay for more intensive and educational public health work; to determine best practices in the administration of urban public health work</p> <p><i>Organizational Structure:</i> Led by an officer of the City's Department of Health with supplemental demonstration administrative and clinical staff</p> <p><i>Goal:</i> To lay the groundwork for city-led neighborhood health centers</p>	Milbank Memorial Fund	1926–1932
East Harlem Nursing and Health Service	<p><i>Care Control:</i> (continues)</p> <p>Independent organization</p> <p><i>Intent:</i> To continue a prenatal and preschool child health service; to develop a public health nursing teaching service for postgraduate students</p> <p><i>Organizational Structure:</i> (continues)</p> <p><i>Goals:</i> Service and teaching</p>	Rockefeller Foundation (service) Milbank Memorial Fund (teaching)	1928–1941
Columbus Hill Health Center	<p><i>Goal:</i> Prenatal and infant health teaching</p> <p><i>Intent:</i> To reduce maternal and infant mortality in one poor, black neighborhood</p> <p><i>Organizational Structure:</i> Nurse-managed</p>	AICP	1916–1938

nurses and independent governing board. But it also uses both the Bellevue-Yorkville Health Demonstration Project and, reflecting the city's segregated public health system, the black nurse-managed Columbus Hill Health Clinic, to enlarge, compare, or contrast the ideas and practices developed in East Harlem. Each of these projects had a distinct focus; yet all were linked through the officers of the city's venerable Association for Improving the Conditions of the Poor (AICP), a private charity devoted to providing health and social welfare services to the city's poor and immigrant families, that funneled the philanthropic and foundation monies that made the services possible.

This book is grounded in three central arguments. First, while it is undoubtedly useful to think of these demonstration projects in terms of traditional metrics of successes and failures, such metrics obscure the day-to-day practices and processes involved in turning ideals about health into normative values shared (and performed) by communities. Change did come: New York City's health demonstration projects eventually established what are now the norms for primary, pregnancy, dental, and pediatric care. But, as I argue, it came almost painfully slowly through the day-to-day work of public health nurses going door to door, street to street, school to school, neighborhood to neighborhood, preaching the gospel of good health to those without access to the resources that class, race, ethnicity, and financial stability provided others their messages. Their messages were certainly reinforced by a new group of public health workers called "health educators." But health educators concentrated on crafting messages for groups—of schoolchildren, church members, or club participants. Nurses focused on individuals and families and, conceptually, on those most difficult to reach.

As importantly, change also came through the efforts of families to first incorporate and then normalize these messages of health by removing them from stigmatizing sites of health and social welfare (in which the public health nurses were located) and placing them within the schools that the community embraced. The nurses in New York City's health demonstration projects slowly moved from understanding their role as bringing "medicine and a message" of middle-class values to immigrant families they wished to assimilate, to conceiving of it as being "more than just a messenger" as they sought to be embodiments of a new emphasis on sound mental as well as physical health. Support for public health nursing did decline in the 1930s as nurses painfully realized that it was "not enough to be a messenger." But the decline was less about no longer serving families who needed to assimilate, as other historians have suggested. The decline, I argue, was as much about families taking responsibility for their health and thereby setting limits on the intrusiveness of the

increasingly intimate public health education that came with the public health turn toward mental health.

I also argue that situating nurses as the focal point of a matrix of competing public health agendas in the interwar year brings into sharper relief the porousness of professional boundaries in times of intellectual as well as social change. While traditional histories of public health nursing have highlighted tensions with physicians, the experiences of nurses in New York City's health demonstration projects suggest those with female social workers held much more salience. In *Nursing with a Message* I chart the how the interwar period's shift of the mental hygiene movement from psychiatry to public health forced nurses and social workers to rethink both their disciplinary practices and their relationships with each other. Social workers, not nurses, had developed the "case work" method for systematically understanding an individual in his or her environment.¹¹ But nurses, not social workers, had the experience and the expertise in the kinds of neighborhood engagement and family outreach necessary for widespread mental health education. What historian Robert Kohler describes as the war-born enthusiasm for science challenged disciplines, foundations, and clinicians to rethink norms about what constituted accepted knowledge and valid evidence.¹² While both nursing and social work drew on the gendered settlement house traditions of simultaneously incorporating research and action in their real-world practices, nursing's claim to science—claims forged in their training school experiences—ultimately strengthened their place in the increasingly medicalized public health hierarchy.¹³ As other historians have argued, faith in science to find solutions to discrete problems, the self-proclaimed "new public health" that now focused on the individual rather than on the environment, as well as the conservative political climate of the 1920s created a perfect storm that decoupled providing healthcare from issues of social justice.¹⁴ In ways we have yet to recognize, public health nurses actively participated in this decoupling process and, I argue, were also central to the success of this refocused and narrower agenda.

Finally, *Nursing with a Message* argues that history is a valid albeit underutilized lens with which to understand current health policy and the processes of health policy changes. In ways that predate what we now describe as the social determinants of health, New York's public health leaders, including nurses, clearly understood the relationships among the conditions in which families lived, the material resources available to them, the access to education available to their children, and their health status. But issues of access and equity to the essential health and social services necessary to allow mothers to raise healthy infants, to help children achieve in school, and to enable breadwinners

to remain productive at work—issues that sound frighteningly similar to those experienced by today’s families from vulnerable backgrounds—remained highly problematic.¹⁵ As this story ends in the late 1930s, migrant Puerto Rican and southern black families—experiencing rampant tuberculosis and soaring maternal and infant mortality rates—had moved into the East Harlem neighborhoods. But they also moved into a more medically driven model of public health that nurses actively built. This new public healthcare model did address the healthcare needs of these new constituents. But it also abandoned issues of housing, education, and employment to the more stigmatized domain of social welfare.

The chapters in this book organize these arguments both chronologically and thematically. Chapter 1 maps the social, political, and public health landscape of New York City as it planned to meet the twin challenges of a new health center movement and more effective tuberculosis control and treatment in the aftermath of the First World War. Prominent social workers and physicians found support from the Rockefeller Foundation to create a health center in East Harlem to test the idea that bringing the twenty-three separate agencies that served the neighborhood into one central building could more efficiently coordinate the delivery of health and welfare services to its Italian and Italian American families. These men also found Foundation support for a public health nursing demonstration within a smaller area in East Harlem that would move beyond voluntary care coordination, as would be demonstrated at the health center, to one of care control. All the nurses in the private agencies working in East Harlem would pool their resources, personnel, and dollars into one controlling organization with its own governing board. This particular demonstration would test some of the more vexing issues in the organization and delivery of public health nursing. At the same time, many of these same men found support from the Milbank Memorial Fund for a “monumental enterprise” that included a health center in the Bellevue-Yorkville neighborhood of the city that would provide a model for how to finally eradicate tuberculosis. The city’s most prominent public health nurses knew of these plans, and some strongly opposed these ideas. But, in the end, I argue, they felt quite comfortable ignoring them. Leading public health nurses were more concerned about education for practice rather than practice itself.

Chapter 2 delves more deeply into the day-to-day realities of the city’s health demonstration projects. It situates these realities amid the tensions between the city’s Department of Health and private agencies and associations over who controlled the public health agenda. Both the Rockefeller Foundation and the Milbank Memorial Fund knew that both the private public health nurses working in East Harlem and the city’s own public health nurses working

in Bellevue-Yorkville were critical to the demonstrations' successes. Indeed, the involvement of the city's own public health nurses working in East Harlem's schools had been a central element of the Rockefeller Foundation's support. The Foundation's policy, both in the United States and abroad, was one of only working through official governmental public health authorities to ensure the sustainability of its initiatives. It hoped to use a consolidated private and public nursing system in East Harlem to ultimately do the same for the city. But, I argue, leading public health nurses shared no interest in this initiative because, in the end, these women won what they had always wanted. By 1928, public health nurses in New York City—not, as in the past, physicians—supervised the independent practices of other public health nurses. They considered this a substantive achievement.

Chapter 3 focuses on the knowledge needed for what contemporaries recognized as “a new approach to health work” among public health nurses. But it is also about how ideas regarding health circulated between and among constituents, how they were implemented, and how their implementation fed back into new policies and practices. It focuses specifically on the complicated and contingent relationships between nurses, social workers, and families at the newly reconstituted East Harlem Nursing and Health Service. Nurses there, like progressive colleagues throughout the country, used their practice experiences to legitimize claims to families as their exclusive domain. They built knowledge that bridged the biological sciences that supported their traditional public health nursing with the new social sciences that buttressed their work with families. This practice, however, brought them out of their traditional disciplinary interests and into a place at the center of their own and also others' agendas. Foundations, families, physicians, and other public health workers all had particular ideas about what nurses should and could do as they delivered their messages of health. As this chapter argues, nurses practiced in a very complicated space of ideas, practice, action, and actors. The knowledge they needed for practice was, in the end, determined not just by the sciences. It was also determined by the demands of the community they sought to serve.

And, as we see in chapter 4, the community around them was changing. The Great Depression had hit East Harlem families early and hard. Its nurses knew about their economic vulnerability, but they thought little of the larger and changing social and healthcare landscape that surrounded them. Through the 1930s Puerto Rican families increasingly settled in neighborhoods of East Harlem. Moreover, these families were moving into a healthcare system increasingly dominated by hospitals and outpatient clinics. I argue that the nurses at East Harlem paid little attention to warnings about the implications

of these new clinical sites for healthcare. They steadfastly maintained the site of their practices to that place where it could be most effectively and independently exercised: with cooperative families in their own homes, in the clinics the nurses controlled, and in the classrooms they created. Despite their commitment to maternal-child health initiatives, this narrow focus allowed them to professionally ignore one of the most pressing public health issues in the city in the early 1930s: the newly rising rates of maternal mortality attributed by both the New York Academy of Medicine and the Maternity Center Association to poor obstetrical practices in hospitals that women were increasingly choosing as sites of their infants' births. These nurses could not see or take responsibility for solving problems that lay inside public health policies but outside their defined disciplinary purviews and sites of practice.

As *Nursing with a Message* concludes, it more deeply examines the policy implications we might learn not just from the demonstration projects themselves but also from the work of the nurses who were their public faces. There may be many lessons learned from the East Harlem and Bellevue-Yorkville Demonstration Projects in New York City—lessons such as the need for small, focused projects rather than “monumental” ones, or the need for such projects to have carefully worked through arrangements with all the constituent stakeholders involved in the public's health. But by focusing on the possibilities and the problems that nurses confronted in their day-to-day work with families, we see other lessons. In the end, the nurses in New York City's health demonstration projects did achieve significant successes. They, along with like-minded colleagues, opened public health nursing to interdisciplinary areas of knowledge long before it was popular. They introduced mental health concepts into the practice of nursing long before they became engrained in nursing school curricula. And they broadened their “new approach to health work” to be more inclusive of families rather than individuals.

Yet their history also provides a cautionary message as we move forward to capitalize on the opportunities afforded by the Affordable Care Act and the calls for proposals from the Center for Medicare and Medicaid Innovation. Disciplinary wishes cannot be separated from the needs of constituent communities. The East Harlem Nursing and Health Service ultimately failed because its commitment was to a particular disciplinary mission that emphasized increased educational opportunities for public health nurses. It did meet these nurses' needs. But the service did not meet the needs of the constituent communities it served. From 1928 to 1941, the service focused more on the educational advancement of public health nursing and less on addressing the real needs of constituents in its East Harlem home.

As we look forward to the Center for Medicare and Medicaid's call for demonstration projects like that of the Strong Start for Mothers and Newborns, projects central to nursing's knowledge and practice domains, we can remember the experiences of nurses in East Harlem as lessons about what might be most important. Disciplinary needs—be it East Harlem's role as a teaching center, or now nursing's wish to demonstrate the power of advanced practice nursing, or medicine's wish to lead medical homes—cannot be separated from the needs of constituent communities. These communities might be narrowly defined as the funders of demonstrations or more broadly defined as the people it serves. East Harlem succeeded when it joined with constituents around the need to create meaningful knowledge about how to care for those at home and in the community. It failed when its mission of knowledge generation through research gave way to knowledge transmission through teaching because of a disciplinary commitment to training a new generation of practitioners from across the country and across the globe not shared by those outside its world.