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Nursing with a Message

Patricia D'Antonio

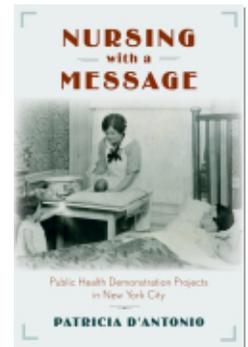
Published by Rutgers University Press

D'Antonio, Patricia.

Nursing with a Message: Public Health Demonstration Projects in New York City.

New Brunswick: Rutgers University Press, 2017.

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The Houses That Health Built

On November 10, 1921, New York City's East Harlem Health Center Demonstration Project (Health Center) opened to great fanfare. The Health Center self-consciously characterized itself as a “department store of health and welfare” playing on the success of a new middle-class institution that promised everything one could imagine buying in one central location. Similarly, the Health Center gathered twenty-three of the neighborhood's health and social welfare agencies into one newly refurbished building for the same kind of “one-stop shopping” for coordinated health and welfare services. The concept of “coordination” was key to the success of the Health Center. Public and private agencies would keep control of their budgets and personnel; but the demonstration would test the premise that physical proximity would eliminate costly service duplication, ease access to resources needed by the predominantly Italian community, and, in the end, deliver better health outcomes.¹

A little more than a year later, in December 1922, its sister demonstration, the East Harlem Nursing and Health Demonstration Project (Nursing Project), started its work with less attention but no less import. Unlike the Health Center, the Nursing Project would be an effort in controlling the distribution of nursing services in one-half of the East Harlem neighborhood. The three private agencies that supported specialized East Harlem nursing services—the Henry Street Visiting Nurse Service (VNS) that focused on nursing the sick in their homes, the Maternity Center Association (MCA) that provided prenatal and home birth services, and the Association for Improving the Condition of the Poor (AICP) that supported tuberculosis nurses—would pool their resources, personnel, and dollars into one controlling organization that would also construct

a research project to prove that a generalized nursing service could more efficiently and effectively serve the needs of the neighborhood for sick nursing, provide maternal healthcare and education, and meet the health needs of the preschool child.²

And, finally, in 1926, the Bellevue-Yorkville Health Demonstration opened in midtown New York City. It had—with some “apprehension”—refocused its goals and agreed to an administrative arrangement that placed the health commissioner in charge and a member of his staff as the director of the demonstration. Within one year of its opening in 1927, however, the Fund found this arrangement “impossible,” with vague allusions to the “handicaps” of working within the structure of the city’s “political machine.” It again reconfigured its mission as a smaller series of demonstrations, some of which—like the use of chest X-rays in the diagnosis of tuberculosis and the provision of materials needed to maintain lung rest through induced pneumothorax—could be adopted later by the Health Department.³

This chapter delves more deeply into the day-to-day realities of New York City’s health demonstration projects. It explores the escalating tensions between New York City’s Department of Health and private agencies and associations over who controlled the public health agenda. These private or, as they referred to themselves, voluntary agencies publicly ceded control to the official agency that the Departments of Health represented. But privately they constantly sought ways to turn this official agency toward their priorities. In New York City, both the Rockefeller Foundation and the Milbank Memorial Fund believed public health nurses were key to this process. Indeed, the involvement of the city’s public health nurses in both East Harlem demonstration projects had been a central element in the Rockefeller Foundation’s support. It could not be a true demonstration of care control, the Foundation believed, unless it involved the city’s own public health nurses who ran the milk and infant welfare stations; who supervised the health of schoolchildren; and who implemented programs of case finding, case holding, and case control of tuberculosis and other infectious diseases. The Foundation’s policy, in the United States and abroad, was one of only working through governmental public health authorities to ensure the sustainability of its initiatives. It hoped to use a consolidated private and public health nursing system in East Harlem to ultimately do the same in New York City.

Historians have long noted the tensions between public and private agencies in setting and implementing a public health agenda.⁴ But public health nurses held no interest in the battles at tables to which they had not been invited. More precisely, the nurses involved in New York City’s health demonstrations

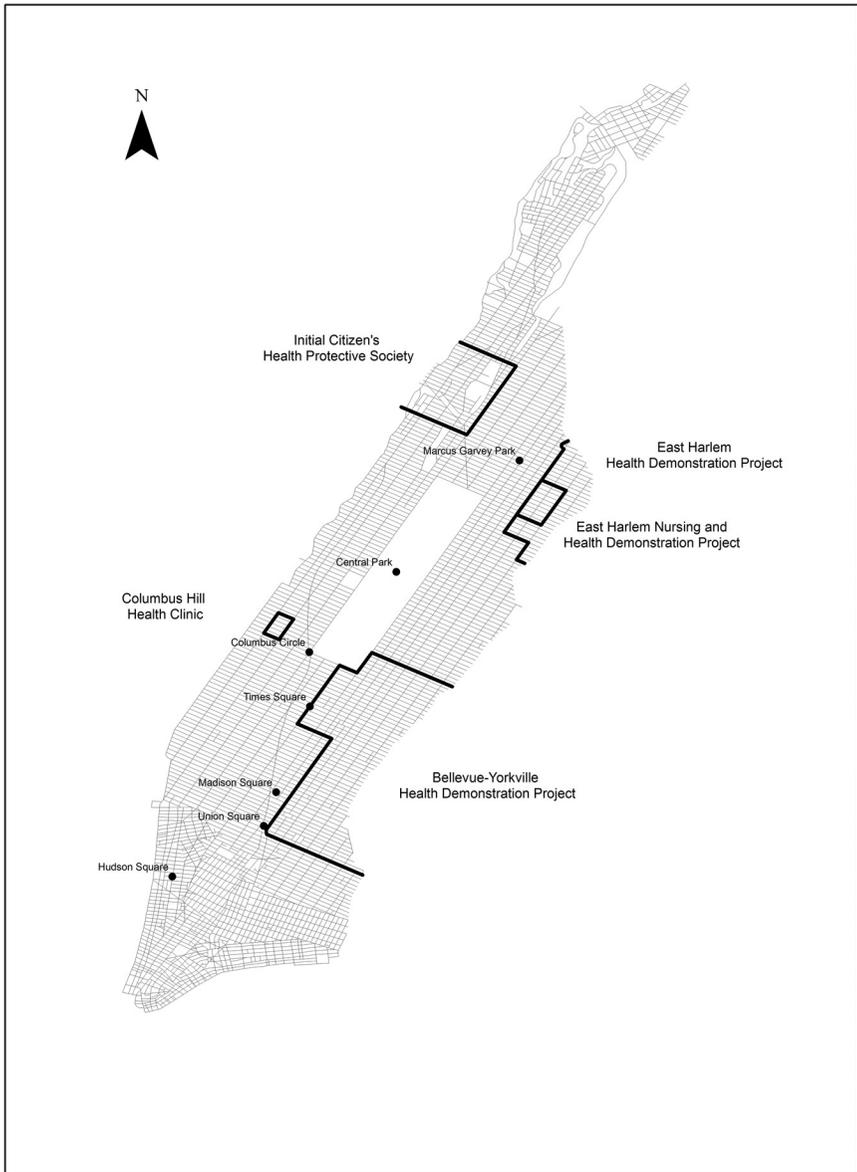


Figure 3. Locations of All of Manhattan's Health Demonstration Projects and Clinics circa 1925

Source: Center for Population Economics (2013), *The Historical Urban Ecological GIS Data portal—New York City, HUE Manhattan Street Centerlines c. 1930* [Data set], <http://ue.uadata.org/gis/>. Retrieved October 2, 2015. Map created by Lisa Hilmi.

shared no investment with their supporting philanthropies in involving the city's own public health nurses in their work. Because, ultimately, they won what they themselves wanted. By the end of the formal demonstration period in 1928, both private and public health nurses in New York City—not, as in the past, physicians—supervised the independent practices of other public health nurses. This was a substantive achievement.

Planning for Practice

The postwar public health practice agenda had also turned its eye to the needs of two groups it believed had been vastly underserved: pregnant mothers, and children too old for services at baby milk stations yet too young for the assessments they would receive when they reached school age. Prenatal care was central to the services offered by the Citizen's Health Protective Society and core to the mission of the Maternity Center Association (MCA). The MCA, born of the early twentieth century's concern that US maternal and infant deaths far exceeded European ones, had grown to thirty small clinics in New York City, including one at the Nursing Project. These clinics offered classes to poor, expecting mothers and hired physicians to provide the medical examinations and treatments they needed.⁵

By 1921, MCA had the data to support its claims that nursing education and medical care before delivery—still largely at home and by lay midwives—resulted in better outcomes for both mothers and their infants. Louis Dublin, Metropolitan Life Insurance Company's (MLI) chief statistician, had found significantly lower maternal and infant mortality among MCA mothers and babies than in New York City as a whole. Looking deeper, he also found even better outcomes for mothers and babies when prenatal care was combined with that during and after delivery.⁶ MCA's grand goal was to make this kind of skilled prenatal and postpartum medical and nursing care available, first, to every woman in the city, and, later, through its pamphlets and its development of traveling educational institutes, to every woman in the country.⁷ But it waged a hard-fought drive against what it believed to be deeply entrenched “half-truths” that childbirth was a natural process and that maternal suffering and death were but God's will. When will mothers and fathers realize, MCA's officers wondered, that the entire pregnancy experience through and after delivery subjected the mother “to such a strain that the margin between health and disease becomes dangerously narrow and the balance can only be obtained by constant supervision and care.” MCA, however, stopped short of completely medicalizing childbirth. It envisioned, and later implemented, a new public health worker. It had begun to lay the groundwork for a “nurse-midwife,” a

skilled trained nurse with postgraduate education in obstetrics that would replace the traditional midwives upon whom poor mothers depended.⁸

At the same time, rising concerns about the physical “defects” found in young American men during draft examinations, and a seeming epidemic of malnutrition among schoolchildren in the immediate postwar period, focused attention on what Yale professor and pediatrician Arnold Gesell had characterized as a vast “wasteland” in public health practice: the health of the pre-school child.⁹ Too often, it now seemed, it was only a schoolchild’s first health exam that discovered the rampant degree to which children suffered from such “defects” as infected tonsils and adenoids, carious teeth, and poor vision. Physicians, as historian Jeffrey Brosco has argued, believed such defects caused childhood malnutrition. And they felt that some cases of childhood malnutrition laid the groundwork for diseases now on the public health agenda radar: tuberculosis, congenital heart disease, and syphilis.¹⁰ But in the absence of any support for universal nursery schools as was implemented in England and increasingly prominent on the Continent, the problem lay in finding these children at home, bringing them in for treatment, and then teaching their mothers about the importance of teeth brushing, good nutrition, outdoor activities, and developmentally appropriate play. And the solution, yet again, was public health nurses who visited such families on their daily rounds.¹¹

Running the Demonstrations

In addition to the existing health and welfare services, the East Harlem Health Center’s three-year demonstration period saw a dizzying array of health and welfare services coordinated, created, and consolidated. Under the leadership of Kenneth Widdemer, the center’s executive director, and with the input of a House Council of representatives of the community and affiliated agencies that ensured its “democratic character,” the Health Center canvassed the neighborhood families to learn about their perceived health and welfare needs and to make them aware of the resources available at the Health Center. It also strengthened its focus on getting adults access to general medical exams as a way to identify potential problems before they became serious diseases. It worked together to establish new cardiac clinics to address what was quickly becoming one of the leading causes of adult mortality. The Health Center also collaborated with the city to provide physical examinations and dental services to East Harlem’s schoolchildren about to enter school; reorganized TB prevention work to more closely follow children deemed at risk; and systematized record keeping.¹²

The services offered, Widdemer admitted, were by no means comprehensive. To accomplish a “complete health job” would have been so prohibitively

expensive that the city's Health Department would refuse to assume any responsibility for its continued existence after the demonstration ended. Moreover, he continued, the true purpose of the Health Center was as a demonstration that care coordination improved health outcomes.¹³ Indeed, one of the key features that attracted the attention and the financial support of both the Rockefeller Foundation and the Milbank Memorial Fund was the health demonstration projects' commitment to carefully documented metrics about its community's health and welfare. One of the most critical social issues in the decades after the First World War was the rapidly escalating costs of medical and nursing care.¹⁴ And the demonstration projects' potential to generate data to improve access, decrease costs, and develop models of effective care that could be used across populations won important philanthropic support that bolstered additional funding from private agencies and public health departments across the country.

The initial three-year data from the Health Center seemed impressive. By 1924, it had served 33,000 individuals in a neighborhood of some 112,000. The calculated costs per capita rose somewhat above the city average to twenty-seven cents. But the numbers of individuals served rose 109 percent. While rates of tuberculosis remained much higher in East Harlem than in New York City, number of deaths from this disease was approaching that of the city as a whole: 38 per 100,000 died from tuberculosis in East Harlem versus 37 in New York City. Infant mortality declined 36 percent by 1923 as compared to the city's decline of 25 percent. And the death rates from all causes of mortality now mirrored that of the city at large: 1,176 per 100,000 in East Harlem and 1,171 per 100,000 in New York City.¹⁵

The Nursing Project, under the direction of Grace Anderson, formerly head of the Municipal Nursing Service in St. Louis, flourished as well. It launched a well-designed comparative study of the effectiveness of generalized versus specialized nursing with carefully matched East Harlem neighborhoods organized either to receive care from an array of nurses specializing in maternity, infant welfare, preschool, and sickness care or else to receive care from one nurse responsible for the health needs of an entire neighborhood. Anderson had started the Nursing Project with a nutritionist responsible for working directly with families whose children were identified as malnourished. But she had quickly switched to a system in which the Project's nutritionist served as a consultant to the neighborhood nurses who would now incorporate nutrition work into their generalized practice. Anderson reworked the Project's record-keeping system to also include length of time of nursing visits to enable another study that would compare the costs of different kinds of nursing home visits. And, she had plans in place to study the nutritional status of children with

pneumonia, a group who made high demands on its bedside nursing service. Anderson's and her public health nurses' work, often invisible in the published reports, substantively contributed to the district's impressive outcomes. And their faces were those most often seen in the neighborhood: two years of data documented 63,500 visits to individuals and families throughout the district.¹⁶ In 1925, the Rockefeller Foundation approved funding for two more years of both demonstration projects.¹⁷

The Nursing Project was a bright moment for New York City's public health nursing leaders. In 1924, they had to close the doors of the Citizen's Health Protective Society. The tensions between nurses from the Maternity Care Association and the Henry Street Visiting Nurse Society over who was better equipped to provide prenatal care were never fully resolved. A tentative agreement had MCA nurses providing all prenatal work and continuing the postpartum care of members who delivered in hospitals, while Henry Street nurses would provide a nurse at the time of delivery for other mothers who delivered at home; Henry Street nurses would continue care through their mothers' postpartum period. But this agreement foundered on the Henry Street director's wish to exert leadership. If, Annie Goodrich tersely informed Olive Husk, the Society's nursing director, a Henry Street nurse met a pregnant mother when in the home delivering sickness care, Henry Street would continue with the family doing the needed prenatal work.¹⁸

But, in the eyes of the nurses, the most serious problem involved the Manhattanville families themselves. Mothers wondered why they should pay for prenatal services they could access for no cost at a nearby Department of Health clinic. They also quickly realized that they could join the Society right before an expected delivery and pay a membership fee that was less than what they would have to pay a Henry Street nurse for care during and after their delivery. They learned to take advantage of a new installment membership fee structure: They would pay one-quarter of a family membership when someone fell ill and then never continued to pay the rest of their membership dues when wellness returned. And, as one young mother frankly questioned, why should she pay for something she did not need? If she were to fall ill she would not need a nurse for a few hours per day; she would need someone to look after her very young children.¹⁹ Nurses prioritized health services; mothers also wanted housekeeping ones.

As alarmingly, the Manhattanville neighborhood was itself changing. As Husk wrote Goodrich in 1922, there had been an increase in the number of inquiries from black families about the services the Society offered. While Husk consistently "discouraged" such inquiries, there still existed a distinct "danger"

that what was to be a white, middle-class insurance program would change into one with a “larger colored service” because of the increasing presence of black families in the neighborhood. Husk and Goodrich shared the assumption that a segregated Society would be the only way to attract the white middle-class families they sought. The Society moved farther uptown in late 1922 to what seemed to be a more promising location at 134 Street and Amsterdam Avenue. This community remained uninterested as well. Husk and Goodrich continued to blame families for the Society’s failure. “Perhaps,” the nurses wondered, “in attempting to popularize a new development, we selected a most difficult district where community spirit and pride and cooperation are little thought of.”²⁰ Yet, the reality was that much colder. While families appreciated health work, they would only pay for illness care. They would not pay for nursing healthcare.

And fissures were emerging in the Health Center’s plans for cooperation. In 1924, the American Red Cross abruptly announced its withdrawal from the national health center movement and now assumed that local agencies would take on increasing financial responsibilities and administrative costs.²¹ And the agencies themselves were rethinking their commitment to coordination. Some had had to redraw their own long-established practice boundaries in New York City to conform to those of the Health Center and others found themselves providing more resources to the families in East Harlem than they did for those in other neighborhoods of the city. Certainly, as Homer Folks explained to Beardsley Ruml, the new director of the Laura Spelman Rockefeller Memorial, in May 1925, there had been some “misgivings” on the part of some participating organizations when plans were first presented to them. But, he continued, the ultimate success “was even greater than anticipated” and all had agreed to continued participation past their initial three-year commitment.²²

But Ruml had begun to hear otherwise. Ruml moved into the tight circle of early twentieth-century philanthropists at an early age. At twenty, he served as the assistant to the president of the Carnegie Foundation; a few years later he served as an advisor to the Rockefeller Foundation; and, in 1922, at the age of twenty-seven, he was appointed to create a more focused philanthropic vision for the Foundation’s Memorial. At his urging, the Memorial had already begun to move away from its tradition of funding health and social welfare projects—moving away from funding individual private agencies such as Henry Street, the Maternity Care Association, and the AICP—and toward a more sustained program of grant support for initiatives in the social sciences.²³ He knew of the difficulties facing the Milbank Memorial Fund as it tried to launch its own New York City demonstration. The “monumental enterprise” had been to build on the success of the AICP’s prewar “home hospital” demonstration. But

this depended on the cooperation of the city's Department of Health—which refused to subsidize the treatment of any adult at home as long as there were empty beds in the city's TB sanitoriums; the commissioner of health—who made it clear that any such initiative had to be “subordinate to” his authority; and to participating health and social welfare agencies—who were quickly losing interest given their experiences with care coordination in East Harlem.²⁴

Ruml launched his own survey on the state of the Health Center in early 1926. If there were, as internal memos noted, a “spirit of cooperation” among those actually working at the Health Center, this did not hold true when discussing the center with the leadership of the participating organizations.²⁵ Issues of privilege and prerogative, colored by class and religious biases, undermined prospects of real cooperation. Certainly, Lawson Purdy, the director of the city's Charity Organizing Society (COS), another of the city's private social welfare agencies, had deep reservations; it actually cost more, he explained, to keep his organization with the Health Center because his social workers were “of higher intelligence and better trained” than those from other organizations and they wasted a great deal of time correcting the mistakes of other agencies' workers.²⁶ Lillian Wald, speaking confidentially, felt the Health Center accomplished little, was very badly organized, and, as it charged nothing for its services, pauperized patients. And, she noted, she thought as little of the Milbank Memorial's project in Bellevue-Yorkville.²⁷ In addition, as Folks did admit, Catholic relief organizations contributed little to the Health Center, placing spiritual values above social welfare work; they were also, he reported, quite content to have the secular AICP take on their cases.²⁸ And Burritt, when carefully questioned about how the health statistics differentiated the work of nurses from that of other workers in the Health Center, found he could not answer. The numbers, he conceded, were “all jumbled together.”²⁹

The case against the Health Center continued to mount. In 1926, Louis I. Harris, the city health commissioner, announced plans to form a new Welfare Council of New York City, an organization that would eventually bring together 332 of the city's largest health and welfare agencies for advice and consultation.³⁰ The medical and policy advisors to Ruml strongly recommended abandoning East Harlem and supporting the initiatives of the Council as they emerged.³¹ In all likelihood, Ruml needed little encouragement. In a tactful letter to Homer Folks in April 1927, he explained how the Memorial had stopped funding projects in public health and public health nursing but that it was aware of the Memorial's historical commitment to New York City.³² The Health Center received bridge funding to mitigate the impact of its closing on the East Harlem community until 1931 when the city took possession of a Health Center

that had devolved into a lay-run Health Shop that dispensed health education pamphlets and created window displays.³³

The Nursing Project, however, hoped to continue and, freed from “jumbled up” measures of its work, begin its journey toward what it would later call “a new approach” to health work.³⁴ In early 1927, aware that dedicated funding from the Memorial would stop in December, the leadership of the Nursing Project convened a “Continuation Committee” of its most important constituents. Chaired by Bailey Burritt, it included Hazel Corbin, the director of the Maternity Center Association and a leading voice in the campaign to train nurses as midwives; Florence Johnson, the director of nursing service of New York City County’s American Red Cross; Margaret Nourse, the president of Saint Timothy’s League, a group of laywomen supporting the Project; Marguerite Wales, now the director of nursing at the Henry Street VNS; Alta Dines, the AICP’s nursing director; and Folks, in his capacity as secretary of the New York State Charities Aid Association and liaison to the Memorial. It also included Grace Anderson, and her assistant, Mabelle Welch, from the Nursing Project. A new constituent, Lillian Hudson, an assistant professor of nursing education at Teachers College (TC) at Columbia University, also joined the group. Students, including those from TC, were an increasing presence in the Nursing Project.

The Committee reviewed the Nursing Project’s impressive accomplishments as it prepared to construct an argument about why it should continue even if the Health Center would not. Its research projects had produced data that contributed to the ongoing debates in public health nursing practice. Its published data supported generalized nursing as the best model for public health nursing practice. In this particular study, generalized nursing practice had outcomes as good as more specialized practices and generalized nursing was more efficient and cost-effective.³⁵ And it had worked with other leading public health nursing agencies to push the boundaries of what kinds of diseases and illnesses would be incorporated into generalized nursing practice. Like nurses at the Henry Street Settlement, East Harlem’s nurses now cared for malnourished children, individuals with tuberculosis, and, in striking contrast with their earlier twentieth-century predecessors, those with communicable diseases.

These initiatives did not go unnoticed by other public health disciplines. In New York City, Lucy Gillett, the AICP’s lead nutritionist, felt the move by the Nursing Project to incorporate nutrition counseling into its nurses’ work “has hindered work in nutrition.” As she wrote Burritt in 1935 summing up a decade of observations, the nurses’ teaching was “perfunctory,” inadequate in difficult cases, and served as a “bad model” for other agencies. She believed the prevailing sentiment among public health nurses was: “If East Harlem can

do it so can we.”³⁶ And the generalized practice of a public health nurse moving, for example, from nursing a child with the measles to teaching a new mother how to care for her infant raised such pressing questions about the potential to spread infections that a special forum at the 1925 Annual Meeting of the American Public Health Association had to be convened. What statistical evidence do we have of such cross-contaminations, the forum queried? None, Wales and other nurses and physicians responded. The real question that emerged from the forum was not one of statistics but of technique, in general, and bag technique, in particular. Both involved scrupulous hand washing with soap and fresh towels; technique extended to the uniforms nurses wore and the extent to which they physically interacted with others in the family; bag technique meant protecting the visiting nurses’ bag with newspapers and always using freshly washed hands to retrieve objects within it. According to Wales and Dines, all techniques were carefully taught and practiced in New York City.³⁷

The Nursing Project’s other research involved the costs of different kinds of public health nursing care. Such data were essential to agencies that had to project budgets, if public, and determine fund-raising drives, if private. It reworked its recordkeeping system to also include length of time of nursing visits to enable another study that would compare the costs of different kinds of nursing home visits. Throughout 1924, its nurses kept detailed records of who they visited, for what reasons, how much time they spent in the home, and how much time they spent on other tasks such as travel, clinic work, and record keeping. Not surprisingly, the data found that postpartum care—care which also involved that of newborns—cost the most per visit (\$2.96) because of the length of time involved (forty-six minutes per visit); sickness care followed, costing \$1.62 for twenty-five-minute visits.³⁸ Surprisingly, the cost of teaching public health nursing students was not recouped by the services they rendered.³⁹ Students were expensive.

As the Committee reviewed the Project’s accomplishments, it became clear that a teaching mission had slowly grown up alongside its service one. Over the past years, it had hosted increasing numbers of public health nurses from around the country; international nurse fellows supported by the Rockefeller Foundation; and postgraduate public health nursing students from TC. As it looked to the future, the Project envisioned expanding its service mission and formalizing its teaching one.

The Committee reveled in the Project’s excellent service reputation. Homer Folks, when reporting to Ruml about the status of the Project, repeatedly emphasized how its nurses broke through an easy sense of futility when assessing the

almost overwhelming health needs of the people of East Harlem with a series of “experimental programs” that magnified its impact.⁴⁰ As early as 1925, May Ayres Burgess, commissioned by the Foundation to do a qualitative study of specialized and generalized forms of nursing in the Project, found the work in both models of public health nursing practice to be “of a high grade,” with “uniformity and poise in the excellent technique,” and “thoughtful and intelligent” in their teaching. She found those nurses who worked under the specialty model more informed with the facts; yet those in the generalized model seemed more informed on the families themselves. Still, she wondered, was it possible that the Nursing Project “overemphasized” technique to the point where families could not follow the nurses’ example?⁴¹ This was an important question as families assumed increasing responsibilities for containing the spread of infections within their own homes.

The Nursing Project also had the strong support of Mary Beard, a powerful presence in public health nursing and now the assistant director of the Rockefeller Foundation’s Division of Nursing Education. “It seems to me,” she noted in 1927 after visiting the Project with the president of the American University in Beirut, it was “far and away the best place to observe health work for mothers and babies in New York. . . . One might easily have spent a week going from home to home with a public health nurse and not have seen so great a variety of health instruction as we saw that morning.”⁴² The Nursing Project’s global footprint was an important strength. As Burritt wrote to John Kingsbury in 1928, Synneve Eikum, the US consultant to Brazil’s first health center in São Paulo, “puffs with pride” every time her center introduces a change that can be traced back to the Nursing Project in East Harlem. Burritt felt confident in describing the Project as “the world’s model health demonstration.”⁴³

By 1927, the Project had answered all calls for bedside nursing; reached 30 percent of all expectant mothers through a new infant service; and had 40 percent of preschool children under its health “supervision.”⁴⁴ It saw a fivefold increase in costs during the past five years, but the families served increased fifteenfold and, despite its commitment to bedside nursing, it maintained a heavy financial investment in their health work with mothers and preschool children.⁴⁵ It had also established its place in the wider nursing community. Grace Anderson published an article describing the Project in *Public Health Nursing* in 1923; and one of the Project’s clerical workers invited readers of the *American Journal of Nursing* to understand a day-in-the-life of a dedicated nursing service.⁴⁶ As importantly, it published pamphlets for widespread distribution to other public health nursing agencies on such topics as the lesson plans it developed for its clinic classes and the procedures it used to incorporate tuberculosis

nursing, nutrition work, and services to preschool children into its program of generalized nursing practice.⁴⁷

The Nursing Project had solved smaller problems as well. It had navigated tensions among its nurses themselves as different nurses from different organizations had different salary structures, different daily time schedules and vacation allotments, and, as importantly, different public health nursing uniforms.⁴⁸ It continued to negotiate tensions with Henry Street as the “vexed question” of charging fees to patients was continuously raised by the VNS.⁴⁹ It took to heart Burgess’s one critique of its recordkeeping system: that it tabulated a visit to one family, for example, with three members under its care as three visits to individuals rather than as one visit to a family. This had important implications when calculating costs per visit, as care to three members of one family mitigated traveling expenses. Internally, the Project began cross-indexing families with individuals in an increasingly elaborate recordkeeping system; externally, it continued to report on individual visits as was normative in public health nursing practice.⁵⁰

As it looked to the future, the Continuation Committee hoped to expand the Nursing Project to the entire East Harlem district and to add more work for preschool children. The Project had taken no initiative to reach out to the Department of Health’s nurses, present in East Harlem’s public schools within the Project’s own jurisdiction and at the baby milk stations in the larger East Harlem neighborhood. But, aware that the Rockefeller Foundation had hoped that the Project would unify both private and public health nurses, it did add its half-hearted hope to work toward a more fully integrated nursing service with the Department of Health.⁵¹ But its real aspiration in moving forward was to fundamentally change the way nurses thought about their patients and how they taught their families. Rather than thinking only about the health content needed, nurses now needed to consider the context in which the content would be delivered. They wanted to engage public health nursing practice more deeply in the emerging mental health and mental hygiene movement. More specifically, they hoped to use ideas borrowed from mental hygiene to think about the personalities of those receiving their messages; understand the attitudes that existed among members of the family of which the individual was but one part; and know the “desirable” and “undesirable” traits that might affect the lives of the mother and child at present and in the future.⁵² Then nurses could begin their health teaching.

The Project then envisioned another new goal moving forward: to forge a more permanent and formal relationship with TC for postgraduate education for public health nursing leadership.⁵³ It fell to Folks to convince Ruml of the wisdom of this expanded vision of the Nursing Project as a service and a

teaching site. Not only had the Project provided excellent, efficient, and more expansive services, Folks argued, it had also served the Foundation well as a training site for the nursing fellows it selected for advanced training from its sites around the world. Nurse fellows from Japan, China, the Philippines, and central and southern Europe trained briefly in the Project and experienced the best practices in public health nursing that they could incorporate into their own nursing once home. It now wanted Ruml to fund the work with Teachers College to establish a formal Institute of Nursing Education for graduate nurses at the Demonstration.⁵⁴

The Rockefeller Foundation balked.⁵⁵ Richard M. Pearce, a noted pathologist recruited from the University of Pennsylvania to become the Foundation's director of medical education for the International Health Division (IHD), had been watching developments in East Harlem with increasing alarm. Pearce's division oversaw the development of nursing as well as medical education in countries in which the Foundation supported public health development projects. He worked closely with Beard, who identified the women chosen for fellowships to study US public health nursing practices; and as early as 1926 she had mentioned to him that a request for additional support for the Nursing Project seemed "inevitable." Pearce, careful to acknowledge that he had no authority over the Laura Spelman Rockefeller Memorial's policies, constructed a memo to his Foundation colleagues clearly outlining what he believed the IHD's position should be. It had no interest in either the Health Center or the Nursing Project. Granted, he conceded, its role in training public health nurses did involve the educational initiatives supported by the Division of Medical Education. But it was completely unrelated to the Foundation's main objective: undergraduate training for public health nurses. The Nursing Project would propose Foundation support of a graduate program, and stand in direct contradiction to its practice of supporting only pre-licensure nurse training schools associated with teaching hospitals of medical schools.⁵⁶

Nursing and the Rockefeller Foundation

The Nursing Project's request came at a turning point in the Foundation's nursing policy. The Foundation had always been clear that its support of nursing was directly connected to its support of medical education and public health, both in the United States and abroad.⁵⁷ From its initial work on hookworm control in the early-twentieth-century American South, the Foundation had developed global programs in medical education, research, and public health. Its commitment to help rebuild the public health infrastructure of war-torn Europe crystallized what, for the Foundation, was the critical issue related to

public health nursing: What kind of education did a public health nurse need for effective practice? It had already commissioned a report on the educational needs of US public health nurses before the war, a report that expanded to include the totality of nursing education in the immediate postwar period. The Foundation subsequently commissioned a second study on those of European nurses in 1921 under the direction of Elizabeth Crowell, the Foundation's nursing representative in Europe.

In the early 1920s, the Foundation had found itself frustrated that there was little clarity or consensus among leading American, Canadian, and British educators about how to train public health nurses or, indeed, nurses. And Crowell frequently found herself at odds with American nursing leaders. Nursing schools in the United States, she wrote in a 1922 letter to George Vincent, the Foundation's president, were too caught up in the web of a professionalizing agenda to provide a model of the kinds of intensive and personalized care that hospitalized patients on the Continent needed. On the other hand, she continued, the rigorous emphasis on higher education and close supervision found in the United States translated perfectly to a robust public health nursing model that would broaden the scope and the practice of the science of public health in both urban and rural areas throughout Europe.

Crowell, although American trained, understood that she was taking a position that seemed like "rank heresy" to her colleagues in the United States. She preferred the English approach. Its hospital-based training schools, run under the stern guidance of long-serving matrons, instilled both the "spirit of service and the conception of the fundamental, therapeutic value of hygiene, diet, and comfort" in the preparation of a nurse committed to a hospital-based career.⁵⁸ As importantly, she remained impressed by an English public health system that allowed for the flexibility of more than just trained nurses engaged in health work. Crowell pressed for England's use of other women in health work, including midwives and lay "health visitors" teaching well families in their communities the basic tenets of good hygiene, diet, and comfort in ways that reflected the different customs and details of their lives.

Moreover, as she traveled through Europe, Crowell remained consistently impressed with the varieties of models she observed for training nurses. She remained particularly struck by France's "Strasbourg Plan." This model explicitly addressed the frequently occurring overlaps between health and social welfare work. It had a core curriculum for both nursing and social welfare students for their first two years of training, followed by a third year of more specialized content that emphasized one or the other particular area of practice.⁵⁹ Crowell, in her 1923 report and in all her communications with the Foundation,

supported a plurality of training sites and models adapted both to the particular scope of Foundation initiatives and to variations in educational standards that were sensitive to the long-existing traditions, prejudices, and politics in particular countries.⁶⁰ This was anathema to American nursing leaders who insisted on a single standard for global nursing education.

The survey on American nursing education officially published in 1923 as *Nursing and Nursing Education in the United States* represented a victory for American nursing leaders, particularly those leaders in public health nursing. Given the current state of education for public health nursing practice, *Nursing and Nursing Education* recommended that all agencies hire only public health nurses who were fully trained nurses with a postgraduate education in public health that included both course- and fieldwork. It did acknowledge different European models of education for public health nursing practice, but it pronounced itself to be “convinced that the teacher of hygiene should be equipped with no less rigorous training than the bedside nurse, further supplemented by special studies along the lines of public health and social service.” It cited Elizabeth Fox, director of the Bureau of Nursing for the American Red Cross, on the importance of visiting nurses’ entrée into families during times of illness that built the trust necessary to return to those families and provide health teaching. “We seem to think,” Fox wrote to Goldmark, “that our American people are most anxious for advice.” Most public health nurses would disagree, she continued. “American people think they know how to run their own affairs . . . and are not anxious to be told by someone else how to do it.” Rather, when the one who nurses them when they are sick and suffering offers advice and suggestions “they are going to take her advice, because it is . . . counsel from a person who has helped them in times of need.”⁶¹

Nursing and Nursing Education also looked to the future. It recommended that generalization be the standard model of public health nursing practice. It also recommended that hospital training schools rework their curricula to reconfigure their thirty-six-month curricula. Henceforth, it argued, a high school graduate with a twenty-eight-month curriculum that emphasized the care of the sick would then have an additional eight months to learn and to practice as a public health nurse. This eight-month frame was not arbitrarily chosen: it was the average length of many of the postgraduate programs then in existence. But by moving postgraduate education into the pre-licensure training, nurses would be better prepared to enter directly into public health nursing.⁶²

But *Nursing and Nursing Education* was not a complete victory. Its recommendation of a shortened pre-licensure course remained one of the most “hotly debated” topics. Critics included Annie Goodrich, the new dean of

the Rockefeller endowed School of Nursing at Yale University, who strongly believed that every public health patient deserved a “fully trained nurse” with strong postgraduate training. Goodrich, of course, believed the curriculum she designed for the Yale School of Nursing produced just such a nurse: Her students came to Yale with two years of college education and had both class and clinical experiences with Amelia Grant, a new assistant professor who also directed the nursing service at the New Haven Dispensary. But as hospitals controlled most other training schools, their insatiable need for staffing would inevitably compromise any attempt to include public health content and field experience. And she had experienced this. Early in her career, as the director of Saint Luke’s Hospital School of Nursing in New York City, she had carved out space to learn and to practice “social service nursing,” an experience that would send the hospital’s most talented students into the homes of its discharged patients for continued care and health teaching. This program quickly collapsed when Saint Luke’s Hospital added new beds.⁶³

None of the report’s recommendations, of course, came as a surprise to American nursing leaders. Nurses Mary Beard, Lillian Clayton, Annie Goodrich, Adelaide Nutting, and Lillian Wald sat on its advisory committee; as did physician supporters such as C.-E. A. Winslow, a chair of Yale’s Department of Public Health and a strong proponent of public health nursing, as well as Livingston Farrand and Hermann Biggs. And most of these men and women were strong supporters of the East Harlem Nursing and Health Demonstration Project that was slowly beginning to establish a presence in the postgraduate education of public health nurses. But the clear rift among its nursing advisors about determining the way forward for nursing, in general, and public health nursing, in particular, in the United States and on the Continent worried Foundation officials. Edwin Embree, still in charge of the Foundation’s nursing portfolio, tried to broker a compromise in 1925 by sending four leading US and Canadian nurses to Europe to survey the conditions of nursing education. Goodrich and Clayton represented the United States. Kathleen Russell, the dean of the University of Toronto School of Nursing, a school that was among the Foundation’s favorites because of its undergraduate attention to public health, and her assistant Jean Gunn, represented Canada.

Of course, these three constituencies almost immediately clashed over Crowell’s choice of two young Czechoslovakian physicians for Rockefeller nursing fellowships. First, there was the very obvious concern about the selection of physicians for prestigious nursing fellowships. Then, there was Crowell’s wish to send them to Yale, where “they would be impressed by the dignity of nursing as a profession and with the fact that the nursing students at Yale

would be on the same level, intellectually, as would be their sister students in the medical school.” Goodrich was appalled that Crowell thought their training as physicians could lead to a shortened period of nurses training. Russell was aghast: She believed that it would be so much for the better to send these students somewhere else as they “ought not be wrapped up in cotton wool, but ought to be made to see the gaff and see hospital nursing as it exists in 99 of 100 institutions.” Crowell won that battle. Goodrich accepted these two physicians at Yale under the threat of sending them to Toronto.⁶⁴

But if she won that battle, Crowell lost the war. Russell and Gunn supported Crowell’s position about flexibility in the models for nursing education.⁶⁵ But Goodrich and Clayton strongly pushed a globalized American model. In a September 1925 meeting with Embree after they returned, they did praise Crowell for what she had accomplished with limited resources. But they felt that the time had come to insist on higher standards for those nursing in Foundation-supported hospitals. Europe, Goodrich and Clayton argued, would develop moderately good schools of nursing on its own. The Foundation’s role should be “blazing trails that later would be generally followed.”⁶⁶ And almost to the day, concerns arose within the IHD about whether the standards for global nursing education were “sufficiently high.” As Frederick Russell, its director, pointed out, the IHD insisted on four to six years of training for public health officers from abroad, and the Division of Medical Education, supporting national fellowships, required “thorough” premedical and medical work. Yet, the Foundation only required one year of training for nurses in Rockefeller-supported European projects.⁶⁷ In October 1925, Vincent called Crowell to New York for a series of conferences to settle the “nursing policy” of the Foundation. But, in fact, it had already been established. Henceforth, the Foundation would only support those nurses and nurse training schools that served as “light-houses” that blazed the American trail.⁶⁸ Those European nurses chosen by the Foundation for fellowships in the United States now needed “weeding out” in more developed training schools in England or on the Continent where their leadership abilities and technical skills could be demonstrated.⁶⁹ The successful candidates could then come as fellows to study nursing education at Teachers College in New York City, nursing practice at the University of Toronto and with the East Harlem Nursing Project, and rural public health practice at the Foundation-supported Vanderbilt University in Tennessee.

Yet the Foundation was beginning to worry about its own “light-houses” in the United States. It hoped that support for collegiate nursing education at Yale, Toronto, and Vanderbilt would create new curricula and training models that would graduate fully functioning public health nurses in as little as two

years at the pre-licensure level. It expected that these “progressive schools” would change fundamental undergraduate nursing courses in ways that emphasized public health as well as bedside nursing practices. Instead, these schools, especially Goodrich’s Yale, seemed to the Foundation’s frustration more akin to “protected schools” in that its students were only relieved of some small part of service obligations on hospital wards and graduated as inadequately prepared to function as fully trained public health nurses.⁷⁰ Left unstated was the opinion of such educators as Goodrich and Clayton that public health nurses needed to be—first and foremost—fully trained nurses exposed to all areas of nursing practice: nutrition and medical, surgical, obstetrical, pediatrics, and mental health nursing. Their model replicated that of medicine: a traditional four years of medical school followed by postgraduate training in newly fashioned and research-intensive Schools of Public Health.⁷¹ The American nurses had won their war.

By 1927 it had also become evident that the Foundation’s administrative structure was too unwieldy. The Rockefeller Institute for Medical Research, and four Rockefeller Boards: the Rockefeller Foundation; the General Education Board; the International Education Board; and the Laura Spellman Rockefeller Memorial seemed to outsiders unrelated, independent, and equally available for grants. And within the Foundation, too many administrative structures created what its officials believed to be a “twilight zone” into which applications that were not obviously within the domain of the humanities or the natural and social sciences might disappear without adequate consideration.⁷² In 1929, the reorganization was legally official. The Foundation now had two boards: the Rockefeller Foundation, which now included the IHD, and the General Education Board. The Memorial was dissolved.⁷³ Nursing initiatives now lay within the purview of the Foundation, with those involving US proposals under the direction of Thomas B. Appleget, one of its vice presidents, and those involving international ones under Pearce. Pearce, as unhappy with the direction of Foundation-funded nursing initiatives abroad as he was at East Harlem, had already ordered a complete review. Pearce asked Crowell to conduct this review. And remember, he warned her in her letter of instruction, the Foundation’s interest in public health nursing education remained at the undergraduate level; responsibility for graduate nursing education, in contrast, lay with the government.⁷⁴

A New Approach to Nursing

In 1927, the still existing Laura Spelman Rockefeller Memorial remained strongly supportive of the actual work of the East Harlem Nursing Project. Moreover, concerns that the pending reorganization might constitute a “public

relations disaster” if no provisions were made for the kinds of charitable philanthropy embodied in the traditional Memorial grants strengthened the Project’s argument for another five-year grant to continue its service mission.⁷⁵ But despite East Harlem supporters’ resolute claims that the service and teaching missions were “inseparable,” the Foundation refused to move in support of graduate public health nursing education that the Project’s teaching service represented. To do so would not only be to contradict its stated policies, but it would be an admission of the dream that someone, somewhere, somehow could create a real undergraduate school of public health nursing.

Bailey Burritt turned instead to the Milbank Memorial Fund. As he wrote John Kingsbury in 1928, the public health nursing teaching that occurred within the Nursing Project had not been part of its original design but rather had been “pressed upon it” from sources of “responsibility and influence.” The plan to fund a formal teaching service represented a “great opportunity” to influence the direction of public health practice.⁷⁶ This opportunity of influence proved tempting. The Fund’s own Bellevue-Yorkville Demonstration was floundering. While Burritt had initially believed that the city would eventually capitulate to plans for Bellevue-Yorkville given that the private Fund had the advantage of time and could wait for changes in public administrations, by the later 1920s he had grown increasingly pessimistic. The health and welfare agencies operating in the district of Bellevue-Yorkville, he decided in 1928, were much less adaptable to political and social pressures than were those in East Harlem.⁷⁷ But neither he nor the Fund were ready to abandon the demonstration. They had recognized that its nurses needed more training if they were to be successful in its planned door-to-door campaign to convince parents, teachers, and key community leaders of the value of providing diphtheria immunizations to their children—seen as a substantive contribution to the city’s success in its campaign to eliminate this deadly childhood disease.⁷⁸

The Fund had recruited Amelia Grant from Yale in 1926 to direct these campaigns as part of a generalized public health nursing service. Yet in 1928, at the same time the Fund agreed to support the teaching service at East Harlem, Grant left the Bellevue-Yorkville demonstration to assume the position as director of the new Bureau of Nursing of the Department of Health of New York City. For the first time in the department’s history, all public health nurses would now report to their own nursing director rather than, as in the past and as was typical of most large urban departments of health, to the medical directors of the various bureaus in which they worked. Grant’s new position and responsibilities were of such import to the field of public health nursing that Lillian Wald made the announcement in the pages of *Public Health Nurse* herself.

Wald described this appointment as “almost without precedent” and as the capstone of a “long deferred wish of pioneer public health nurses.”⁷⁹ Indeed, members of the Board of Managers of the Bellevue-Yorkville Demonstration, reflecting on their work in 1933, felt that bringing Grant to New York City and then letting her go to the Department of Health had been, perhaps, “the most outstanding contribution of the Demonstration.”⁸⁰

The Nursing Project, now secure in another four years of support from the soon-to-be-dissolved Memorial, the commitment of the Milbank Memorial Fund to its teaching service, and the resources of the four cooperating nursing agencies, set about to create a formal “family nursing service” that would represent a “new approach to health work” by more fully integrating knowledge from nutrition and mental hygiene into their work. As the representative agency in East Harlem for the HSS Visiting Nurse Service and the Maternity Center Association, it would use the “medical-nursing approach” of these “covering” services as the basis to build the “relationships for the educational work that would continue long beyond the acute need for the initial service.”⁸¹ It would develop a “common program of health education” that would be carried into the home by one nurse whose relationship with the family would continue over time.⁸² In 1928, the Nursing Project brought the demonstration part of its work to a close, and reopened as the East Harlem Nursing and Health Service.

