Nursing with a Message

Patricia D'Antonio

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Chapter 4

Shuttering the Service

New York City's nurses and social workers witnessed firsthand the devastation wrought by what was at first haltingly described as a "business depression," or an "emergency." The Research Bureau of the city's Welfare Council, the now new and privately funded agency also addressing the issue of coordinating the delivery of health and social welfare services, turned to them to gain an initial "impressionistic" view of the plight of families and individuals during the harsh winter of 1930 and 1931. Some nine hundred women making close to their normal four thousand visits to homes each day between October 1930 and May 1931 participated. Most of these women had the kind of long-standing service in their neighborhoods and communities that allowed them to compare conditions before the economic collapse with the current ones. They saw "an unusual and disturbing amount of suffering." They saw cases of "actual destitution," and families on the brink of such destitution because families and friends they might normally rely upon were in similar circumstances.[1] Social workers felt grim. They experienced dramatic increases in cases, often marked by what they believed to be expectations for financial assistance rather than more humble and embarrassed requests for any resources that might be forthcoming.[2]

The city's public health nurses, such as those working in the schools in the Bellevue-Yorkville Demonstration, noted difficulty in evoking interest among parents in their messages of health education for their children. They remained sympathetic, noting that messages about, for example, dental hygiene, would not become a priority among parents "who were worried about the rent and the next meal."[3] Those at the Henry Street Settlement's Visiting Nurse Society remained adamant about separating their bedside nursing from any kind of

relief work. Unlike groups such as teachers and police officers who had devised impromptu relief strategies, they believed, echoing Wald's need to maintain the boundary between nursing and social welfare, that such work would be distracting from its core mission of nursing the sick.[4] But, overall, public health nurses in both public and private agencies felt cause for optimism about the long-term effects of the economic crisis on the future of their discipline. Perhaps, they wondered, "the time and attention they gave to helping people about their economic problems in time of need may bear fruit in a greater willingness to heed the advice of a nurse when she goes to them about matters of health."[5]

Nurses at the East Harlem Nursing and Health Service knew of the effects of this massive economic collapse. The Depression and the accompanying unemployment had hit the community early and hard. An informal survey of families receiving its services in January 1934 found 73 percent dependent on outside sources of income; 24 percent with a bare subsistence income; and a mere 1 percent as moderately comfortable. A more formal 1934 survey of 602 families found 61 percent of families on relief; and of the 37 percent still described as "self-supporting," 22 percent were still vulnerable as they were living on savings or with other family members.[6] Yet, East Harlem nurses also felt reason for optimism. "In the face of the depression conditions, these families have maintained their morale and their children's health to an amazing degree."[7]

But if the East Harlem nurses knew about their families' economic vulnerability, they thought little of the changing social and healthcare landscape. Throughout the 1930s, Puerto Rican families increasingly settled in the neighborhoods of East Harlem. Moreover, these families were moving into a public healthcare system increasingly dominated by the rise in hospitals and outpatient clinics where families increasingly sought medical care. This chapter argues that the nurses in New York City's demonstration projects paid little attention to warnings about the implications of these new clinical sites for public health practice. They steadfastly maintained the site of their practices to that place where they thought 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 ignore professionally 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.

A Changing Landscape

In many respects, East Harlem Nursing and Health Service faced changes over which it had little control. First, the Service had no permanent home since the deed to the American Red Cross Building that housed the East Harlem Health Demonstration Project passed to the city when it finally came to an end in 1932. The Service maintained a temporary residence in the building, but it was not until 1934 that a philanthropist deeded to them the building that housed the short-lived Kips Bay Day Nursery that she had supported. While grateful to have a final home, that building lay in the northeast rather than the central section of the district, and attendance at the Service's clinics dropped by 20 percent. Given the travel distances involved, the nurses advised parents who lived in the southernmost section of East Harlem to register their children at the city's Baby Health Station serving that area. The Service now served a smaller community of 57,000 individuals. But it claimed that its "family health service" reached 63 percent of the community's newborns; 40 percent of its preschool children; and 21 percent of its maternity cases. More telling, however, was a Service that had always prided itself on meeting all calls for sick nursing in homes now reported without comment that it met only 34 percent of neighborhood's need for "traditional bedside nursing."[8] The Depression had certainly begun to take its toll. But it had also provided a subtext for the Service's move from more traditional and labor-intensive practices where private public health nursing had been in the past to the focus on the public health teaching where it wanted to be in the future.

Also, the Depression had rocked private, voluntary agencies that could not meet overwhelming and legitimate needs for economic relief. In a complete reversal of numbers attending its opening in 1922, 98 percent of East Harlem families needing relief were now supported by state and federal agencies; only 2 percent received support from private agencies. Until the 1930s, these social workers had been employed by the private agencies that had long supported the material needs of East Harlem families nursed by the Service. Now, they too faced crushing caseloads, dwindling resources, and a steady erosion of the time needed for the personalized, face-to-face interactions demanded by their casework method. Those few who could, moved into private, fee-based marriage and family counseling practices. The many who could not either found themselves

Figure 5. The Children's Play Room at the East Harlem Nursing and Health Service
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unemployed and eligible for relief, or joined the increasingly bureaucratic arrangements that first city, then state, and then federal relief programs needed for their administration.[9] These arrangements were now highly gendered. As a 1935 Welfare Council report noted, "women now occupy the great mass of the poorly paid positions upon which the social work structure rests."[10] And they were fraught with distrust. As historian Daniel Walkowitz has argued, many political opponents of publicly funded relief programs remained profoundly suspicious of the true needs of those deemed eligible. The city's own internal memos reminded its social workers to limit their investigations to eligibility determinations; it was "not . . . to deal with personal and family problems."[11] On the one hand, the East Harlem Nursing Service could now lay sole claim to the disciplinary prerogative of family nursing.

Yet, on the other hand, those same federal dollars undercut their community focus. Fiorello LaGuardia, a child of East Harlem and now the mayor of the city, was committed both to public health (his first wife and their child died of tuberculosis) and to the new federal construction dollars available through the Work Projects Administration. Under his watch, the city secured millions of dollars to expand dental screening programs, provide preschool health exams, add public health nurses to the Health Department rosters, to build hospitals,

and, with the full support of the Welfare Council, to bring a neighborhood health center to twenty identified districts in the city.[12]

Neighborhood Health Centers

The roots of this return to neighborhood health centers lay in the same impulses and the same men that supported the city's health demonstrations in East Harlem and Bellevue-Yorkville in the earlier 1920s. But this was a broader approach to a city in which there existed a "wide gap" between those working in health fields and those interested in community development. These gaps were geographical: the reach of hospitals, dispensaries, settlement houses, community centers, and neighborhood associations cut across the Department of Health's division of the city into "sanitary areas" coterminous with census tracks, leading to confusion as to which organizations provided which services to what neighborhoods. These gaps were also about authority, class, and ethnicity. As John Gebhart of the Association for Improving the Conditions of the Poor (AICP) had previously argued in a 1923 meeting, it also involved the kinds of expert knowledge needed for effective action. "Lay interference" from members of the community itself, he announced, "unreasonably delayed or frustrated" expert judgment on action needed.[13]

The appointment of Shirley Wynne as the city's reform-minded health commissioner in 1928 spurred new interest in broadening the health center movement. Wynne appointed a formal Committee on Neighborhood Health Development in 1929, convinced that the delivery of health services should be nested in not only the needs and but also the voices of the particular neighborhoods it served. But his tone, as befit the politics of his position, was different than Gebhart's earlier one. In his vision, such neighborhood health centers represented the "democracy of public health" that would make living in a congested, complex, and at times impersonal city more hospitable. Such health centers, then, would exist as a "living part of the activities of people in the neighborhood."[14]

Wynne had followed the work in East Harlem with interest. It had "demonstrated," he wrote, that bringing together voluntary and public health and welfare agencies prevented duplication and improved communication. Wynne also knew that it increased costs that he also hoped to contain. As the nominal leader of the Bellevue-Yorkville Demonstration Project he increasingly steered its focus to the best and most efficient administrative practices in public health. Increasingly, Bellevue-Yorkville had moved to testing different forms of administrative structures, new clinical services, and ways to organize the

necessary drives to ensure the immunization of children and the adoption of periodic medical exams for adults.[15] As Edward Devine, the new director of the Bellevue-Yorkville Demonstration, explained to an audience of community members in 1930, although called a demonstration, "we are not demonstrating anything. . . . We are carrying on as an experiment station."[16] Bellevue-Yorkville had moved beyond an emphasis on the wider spread application of known knowledge to a place that would generate new knowledge.

The work at the Bellevue-Yorkville Demonstration presaged many of the initiatives that would later be transferred to neighborhood health centers. It reorganized the Yorkville Tuberculosis Clinic into a Chest Clinic built around a new X-ray machine for diagnosis and a new system of records for follow-up visits. It forged links with the Bellevue Medical School Clinic that developed a new system of contact tracing for instances of venereal diseases. It established a Diagnostic Cardiac Clinic for children in an attempt to identify and treat those cases of rheumatic fever that they believed to be a leading contributor to the place of cardiac disease as one of the leading causes of adult mortality.[17] By 1932, the Bellevue-Yorkville Demonstration boasted of other leading accomplishments now increasingly practiced by the Department of Health throughout the city.[18] This included the department's first generalized nursing service that was to be the cornerstone of the health center movement. Indeed, the "initiative and the perseverance of the Bellevue-Yorkville nurses," its 1930 report noted, "was the most important factor in the successful operation of the whole service." Bellevue-Yorkville, in fact, had enlarged the scope of generalized nursing to include recreational as well as social, mental health, and nutrition support to families. "In public health work," it concluded, "the ability of the nurse to judge the problems of a family as a whole rather than just deal with one factor in the situation is an unquestioned advantage."[19]

The private Welfare Council weighed in with its own opinion. Its 1929 report, *A Health Inventory of New York City*, presaged the changing healthcare landscape. Constructed by the well-known healthcare reformer, Michael Davis, the inventory noted the problems that spurred the development of health demonstration projects: the lack of public and private coordination; the inequities of the distribution of health services that saw Manhattan with only 30 percent of the population of New York City served by two-thirds of all the private agencies; and services developed with little reference to a neighborhood's needs.[20] But he also noted changes that he believed to bode well for the future. He was impressed with the rise in the number of hospitals whose own outpatient clinics took health prevention and care coordination more seriously. He also saw the sharp increase in numbers of individuals across the city using these clinics.

And he believed in what he called the "dissolving" boundaries between private medical practice and public health promotion as individual physicians slowly incorporated medical exams and health teaching into their adult and pediatric practices.[21] Davis was less enthusiastic than many about the plans to carve the city into health districts. The entrance of hospitals as increasingly important institutions in the healthcare area, he believed, had a "radical" effect on the delivery of healthcare services and diminished the need to think about a health center in those areas well served by these institutions. Perhaps, he speculated, it might be better to think about health districts only in relationship to the need for home visiting nursing services.[22] This, of course, echoed the structure of the Henry Street Settlement and Visiting Nurse Service with its branch offices throughout the borough of Manhattan.

This recommendation also fit well with the direction and ambition of the East Harlem Nursing Service advisors, many of whom, such as Bailey Burritt, Homer Folks, Hazel Corbin, Lillian Wald, and Amelia Grant, also served as consultants to the *Inventory.* But Burritt, in his role as director of the AICP, also forged a link with the health clinics his association supported, not only in Columbus Hill but also in other underserved areas of the city such as Bowling Green and Mulberry Bend. The AICP, he wrote now Mayor Jimmy Walker, could provide the city with a "tested plan," not an "experiment" in how to organize and implement its health centers.[23] The first neighborhood health center opened in Harlem in 1931 to serve what had been a largely neglected and increasingly disaffected black population suffering from high rates of tuberculosis and maternal and infant mortality. Some monies had been set aside before the Depression for the construction of several additional health centers in "so called sore spots" in Manhattan on the lower West Side, in Mott Haven in the Bronx, and, in Brooklyn, in the combined neighborhoods of Red Hook and Gowanus and Williamsburg and Greenpoint.[24]

But LaGuardia's success in garnering federal dollars breathed new life into this movement. It also breathed new life into the Rockefeller Foundation's long-standing wish to more closely align government-funded public health departments with public health education in medicine and nursing. There was precedent: The two leading schools of public health, at Harvard and Johns Hopkins, had affiliations with local departments of health in nearby neighborhoods. But there was also a history. Wynne had four years earlier approached New York University about a possible affiliation and found "absolute opposition" from the University because of the politics surrounding "unpredictable" relationships with the city's Health Department, then staggering under allegations of widespread graft and corruption.[25]

But by 1934, Cornell University emerged as a possibility. A Rockefeller-funded pathologist, Eugene Lindsay Opie, wanted to extend his research on tuberculosis to the neighborhood surrounding Bellevue-Yorkville,[26] and Cornell itself hoped to develop an undergraduate department of public health. Although "loath to put itself in the hands of the city's Health Department," the University did agree to begin negotiations if it could appoint a "strong" professor of public health to the Health Center and could create "satisfactory" teaching arrangements for its public health and medical students. By 1935, the Foundation felt confident enough in the eventual success of these negotiations that it reserved $240,000 for the eventual creation of the "Cornell University Medical College Health Center of the New York City Department of Health." The Milbank Memorial Fund agreed to support this proposal by donating the monies it received from the sale of the then Bellevue-Yorkville Demonstration building. All participants joined in believing in the potential of this Health Center to become an "exceptional" urban health center and teaching site.[27] The Rockefeller Foundation also hoped it would solve the problem that the East Harlem Nursing and Health Service had become for it.

Public Health Nursing in the City

In 1934, New York City's Department of Health commissioned a study on "Some Special Health Problems of Italians in New York City" in conjunction with two newly planned, federally funded neighborhood health centers uptown in East Harlem, and in Mulberry Bend, an area west from the Bowery to the Hudson that at the time was the neighborhood with the second largest concentration of Italian and Italian American residents in the city's Lower East Side. By all mortality measures, the residents of East Harlem experienced "distinctly better" rates than those in Mulberry Bend. The overall mortality rate in East Harlem was 10.86 per 100,000 versus 12.84 in the city as a whole, a "most creditable" achievement. Residents of East Harlem died from pneumonia, diabetes, cancer, tuberculosis, influenza, and communicable diseases. But the rates of death from these diseases remained lower than in the city as a whole. Only diabetic deaths remained higher but, as the report pointed out, these rates still remained lower than those in Mulberry Bend. Mothers, infants, and children also died at rates lower than that of the city. The reason seemed apparent. It was because of "the intensive health work carried on in the district by the East Harlem Health Center." The shadow of that past project extended further. "There is every reason to believe," the report concluded, that the new downtown health center would "improve health conditions in that district to a considerable extent." No longer would

its residents die needless deaths from pneumonia, tuberculosis, venereal diseases, and diabetes.[28]

Of course, the driving force behind this success lay with the work of its public health nurses, often acknowledged in print reports and memorandums but, as in the past, rarely refracted in data. They provided the bedside care of individuals with pneumonia, visited pregnant mothers and their infants in their homes, cared for individuals with tuberculosis and taught their families how to prevent cross-infections. By 1934, 75 percent of all the care and education delivered by the nurses at the East Harlem Nursing and Health Service were to mothers and their families in their own homes. They had incorporated communicable diseases into their traditional tuberculosis practices. They worked closely with physicians to implement plans for periodic medical exams for men, well-baby checkups for children, and prenatal exams for mothers; but their own role was to work with individuals and convince them to access follow-up care if "defects" were found. Examinations without such follow-ups were "futile" and nurses needed the "time and ability and energy" to make this happen for children as well as adults.[29]

East Harlem, still relatively financially secure, staved off the immediate effects of the Depression. Bellevue-Yorkville, dependent on nurses whose salaries were paid by the city's Department of Health, could not. As early as 1932, it had reduced the hours of its mental hygiene consultant and began practicing "rigid economies." Bellevue-Yorkville had also begun an "experiment," sending letters home requesting that mothers come to its schools to discuss "defects" found in their children's health exams rather than, as in the past, going to families in their own homes. By 1933, the Demonstration's experiment had shown what they framed as "most encouraging results." Thirty-seven percent of mothers who received such a letter took advantage of such appointments and came more prepared to address their children's health needs. As the convention in both private and public health nursing recorded a "visit" as a nurse calling on the family at home irrespective of whether a parent was home or answered the door, this report remained silent on whether or not this strategy reached more or fewer families. But one brief survey that tried to capture points of resistance to school visits found that 29 percent of families reported that they had never received a letter from their child's school; 28 percent said they were "too busy"; 15 percent had to nurse a sick family member; and in 9 percent of families both parents worked. Parents had again structured their own, often multiple places of action, some incorporating active points of resistance to outsiders inserting themselves into private matters and others reflecting the realities of their busy and often over-burdened lives.

School, rather than home visits, however, had as important an impact on public health nursing practice. Ostensibly much remained the same. When parents did come to the schools, the nurses used such opportunities to talk with mothers, not only about a particular child's health, but also about the physical, social, and economic difficulties the family as a whole faced. The home visit still had a place, but it was a much shorter one reserved for instances when nurses suspected children of experiencing infectious diseases or displaying difficult behavior problems. Those involved recognized that valuable information was lost when nurses did not visit a child's home. But the Bellevue-Yorkville nurses did find parents' attitudes "more satisfactory" when they voluntarily came to the schools.[30] The convergence of the Depression and Leonard Covello's wish to push health education out of systems of social welfare and charity did create more choices for parents reluctant to invite strangers into intimate family spaces. But this new system pushed to the margins those most difficult to reach and those most in need of assistance. Tensions had long existed between the city's public health nurses who had to—by law—deal with all "troublesome cases" and those at private agencies—such as those at East Harlem—who had more freedom to choose the individuals and families with which to work.[31] But now school rather than home visits gave the city's public health nurses more control over their practice. Moving forward, the city's school nurses now had a mechanism that—if they so chose—could keep at bay those they were reluctant to engage.

Nursing East Harlem

With more financial stability, East Harlem tried to maintain its home-based focus. But the home and the family inside were changing. Because of immigration restrictions, by the mid-1930s 60 percent of the population of the East Harlem Nursing district was born in the United States and only 30 percent had been born abroad; and the Service had noticed a decreasing demand for Italian translators.[32] Birth rates to young parents had plummeted more than 50 percent; and families were growing smaller in size, a trend abetted by a neighborhood birth control clinic and noted with approval as the East Harlem nurses felt that the children received more and better attention. Infant mortality had fallen to 56 per 10,000, as compared with 74 in 1923. But maternal mortality remained more intractable: its prevalence remained the same as in 1923.

As significantly, almost overnight hospitals had replaced homes as the preferred site of births and physicians had replaced midwives as the preferred attendant. Up until 1927, 85 percent of births had been in the home; by 1934, 65 percent occurred in hospitals. "Young mothers," Anderson reported to her

board of directors in 1935, "look upon hospital care quite differently than did their foreign-born parents." Two outpatient medical clinics (including one nested inside East Harlem's Nursing and Health Service, staffed by nurses from the Maternity Center Association) had closed by 1933 as physicians' care now came though hospitals, hospital-based outpatient clinics, or private medical practices. The East Harlem nurses' first responsibility now was to ensure that families registered at the hospital in which they hoped to deliver as soon in their pregnancy as possible. Then they would begin their own work. Their overarching goal remained a safe pregnancy for both mother and child. But their "new approach" also meant using the prenatal and postpartum periods of home visits as a "starting point for the continuous program of parent education and child health supervision."[33]

Declining birth rates meant fewer children, but, Anderson continued, more intense involvement with families. Each family, on average, received nine visits during the prenatal and postpartum period from an East Harlem nurse: Blood pressure readings and urinalyses were also part of the visits. The overall average number of visits for all families combined approached twelve, suggesting some families received more intense scrutiny than others. Mothers who, according to the nurses' own, personalized evaluations, seemed "most alert" to the nurses' message received additional support in group meetings at the Service; those deemed "less alert" came to the Service for additional, individualized meetings. Fathers could participate in a "Fathers' Club" where a male leader led discussions about marital relationships and family problems. The Service also started a new Child Health Conference where mothers gathered with all their infants and preschool children to learn about normal growth and development, nutrition needs, the need for appropriate recreational activities, and to socialize with each other. All told, the Service boasted about reaching three-quarters of the districts' childbearing families.[34]

Anderson publicly boasted that East Harlem successes with families rested with her nurses' "techniques and sympathetic approach" that successfully "draw the parents out, recognize and give meaning to their experiences, direct them to knowledge or agencies where help may be secured, and yet leave them with a feeling of freedom in making their own plan."[35] But some other nurses at the Nursing Service refused to incorporate these tenets into their practices. Like their physician colleagues when approached to incorporate periodic medical exams into their practice, they had not been trained in the precepts of mental hygiene in their training schools and saw no need to learn them now. Sybil Pease, still East Harlem's consultant in mental hygiene, spent a considerable amount of her time working with these nurses. Anderson, in fact, believed

Pease's "best work" was with "those who needed considerable personal help to be intelligent workers in the mental hygiene field."[36] Some nurses, like the families they served, drew limits around the psychological intrusiveness required to practice this "new approach."

Nor was this new approach as easy to practice as it was to learn. As Anderson fretted to Mary Beard, still a staunch Rockefeller Foundation supporter, in 1937, "nurses are not born teachers." In fact, she continued, "for the most part they are particularly poor teachers until they have the time and opportunity to learn what and how to teach." Her challenge was to help her nurses incorporate the Service's "slogan" of "helping parents help themselves—help them formulate their own problems, ask their own questions, and then see how busy they can keep us trying to answer them."[37] Anderson constantly worried about the place of mental hygiene in public health nursing, in general, and the Service's responsibility to the mental hygiene movement, in particular.[38]

This emphasis on helping parents help themselves, in fact, slowly turned the Service away from its tradition of home visits toward clinic-based ones: Families who wanted to help themselves would take the initiative to seek out the help offered by the Service. By 1936, 41 percent of all services offered took place in clinics and health conferences inside the Service. "We aim to eliminate," Anderson announced to her board, "as far as possible, over-visitation in the homes and to encourage more activity on the part of families themselves" to come to the Service for classes.[39] Financial exigencies had now fully merged with middle-class expectations of initiative and independence. Beard noted to the Rockefeller Foundation on her routine visits to the Service "that the whole house was filled with the activities." Indeed, she continued, "all mothers were there by appointment, the appointment system having been as thoroughly developed here as in any private doctor's practice."[40] Yet while Anderson dreamed of a future in which the Service could develop "the methods of basic nursing services, of progressive education, and of case work," parents dreamed of one that included more recreational activities, like dances, and of turning the roof of the building into a "play school" for their children.[41] They dreamed of one geared more to their social than their health needs. Boundaries between health and welfare existed for clinicians, not for the families they served.

Nationally, critiques were developing as leading public health nurses in agencies across the country adopted this "new approach" that increasingly focused on the interior psychological life of their parents. Some public health nursing leaders, while supportive in concept, worried that this emphasis on the science of mental hygiene left nursing as vulnerable as medicine to charges that it had lost its sense of social justice: that the turn away from external health

threatening environments blinded nurses to the real causes of health and illness.[42] Others worried that the drift away from traditional bedside nursing and toward teaching in families' homes weakened nurses' place in the public health hierarchy. Thomas Parren, the surgeon general of the United States, and Mary Roberts, the editor of the *American Journal of Nursing*, joined ranks in 1939 by urging public health nurses to "get back to the middle of the road" by reuniting the more "concrete and the educational" functions of nursing. Roberts went one step further: She encouraged public health nurses to return to hospitals for postgraduate courses "in the newer methods of caring for patients."[43] Donald Armstrong, late of the Framingham Study and now the vice president of the Metropolitan Life Insurance Company, was more direct. Physicians, he warned public health nurses, do not understand the notion of the "talking nurse."[44]

The Changing Landscape

But these were not the only families who needed the Service. More and more, families from Puerto Rico had settled in East Harlem in the same old-law tenements that a second generation of more middle-class Italian Americans had fled by moving to the developing Bronx. And, in the midst of a Depression these families experienced the same lack of access to good jobs that would feed and clothe their children. This dismal environment, not surprisingly, brought with it a resurgence of tuberculosis, other infectious diseases, and shockingly high rates of maternal and infant mortality in East Harlem.[45] Many, if not most, of these families settled in the southern section of East Harlem, the neighborhood the Service had suggested access the closer Department of Health clinic when it moved to its new Kips Bay building. But the experiences of nurses in Columbus Hill also suggested not only a certain weariness in the face of a resurgence of an old enemy, but also a wish to avoid, again, the complicated intersection of race and class that came with changing neighborhoods. Columbus Hill had undergone its own demographic transition as black families from the West Indies had moved out and those from Virginia, Philadelphia, and Newark had moved in. In the eyes of these nurses, these newcomers were more akin to a "cabin type negro" who had "no idea of housekeeping, home making, hygiene, or their privileges as citizens." There was "no question," they continued, that public health nurses were the best experts to build both "healthy men and women" and "conscientious citizens." But they felt they were working against "great odds." Though their staffing remained constant, their caseloads were decreasing because these families needed so much of their time. They wanted to expand the boundaries of their district to include the neighborhoods to which their West Indies families had fled. These older families, they insisted,

were just at the point "where intensive health education can really begin." These families, they concluded, were "well worth their time and attention."[46] Whether at Bellevue-Yorkville, East Harlem, or Columbus Hill, public health nurses unwittingly withdrew resources from families that would not follow their advice to concentrate on those who showed more interest in their physical and mental health messages.

Traditional sick nursing care seemed increasingly irrelevant to their work.[47] It was not that there were no calls for such services. In 1936, for example, East Harlem received 1,070 such calls. But now the vast majority were for children with respiratory illnesses who had fewer hospital resources rather than adults did.[48] And hospitals were an increasing part of the healthcare landscape. These included the large, teaching hospitals famous throughout the country. But more worrisome were the small, private maternity hospitals sprouting up where mothers went to give birth—and, often, to die. Rates of maternal mortality in the city remained stubbornly high—higher, the Maternity Center Association (MCA) constantly pointed out, than any other civilized country. In Bellevue-Yorkville, they remained at approximately 6.2 deaths per 1,000 from 1922 to 1929, particularly problematic since mothers in the neighborhood's MCA clinic had experienced only 2.4 deaths per 1,000.[49] Similarly, they were 4 deaths per 1,000 in East Harlem where MCA also had a clinic. Yet in the city overall there were 5.1 deaths per 1,000.[50] Public health officials knew that these broad numbers needed some "nuance": in some parts of the city maternal mortality was a "negligible" concern.[51] But, they believed, in poorer neighborhoods maternal mortality was a "heart-rendering problem."[52]

And they believed they knew the cause. As both George Kosmak, the chair of MCA's board of directors, and Lindsey Williams, the new commissioner of health for New York City, constantly reiterated as they joined to launch a new and national educational campaign in 1930: A hospital confinement is not necessarily a safe confinement.[53] But it took the release of a 1934 study by the prestigious New York Academy of Medicine to drive that message home. The Academy surveyed the causes of all instances of maternal mortality in 1930 and 1931. It placed responsibility for two-thirds of all causes of maternal mortality at the feet of "incompetent practitioners" and on the fact that "conditions in hospitals [were] far from what they should be." It reported the dramatic increase in "operative deliveries, especially caesarian sections," and anesthesia by physicians with little experience. It noted the lack of any public or medical oversight on issues other than "minor points" of sanitation. It did not let mothers off the hook: 36 percent of maternal deaths were believed to be caused by their reluctance to seek prenatal care or their turn to induced abortions. Midwives still

attended 10 percent of the births in New York City and their "meager supervision" resulted in the final 2 percent of all causes of maternal mortality.

Under MCA's leadership, a day-long symposium on "Community Responsibility for Improving Maternity Care in New York City" gathered together leading physicians, nurses, reformers, and interested lay women in 1934. The reports of the afternoon roundtable discussions revealed the intransigency of the issue of maternal mortality among poor women. A eugenics argument was brought to bear: The high rates of Caesarean sections could be explained by the "problems of certain kinds of men and women mating." An argument about a flawed study design was proposed: The criteria used to judge whether or not a maternal death could have been avoided was "utopian" and did not account for women arriving in an already "hopeless state" to municipal hospitals already overcrowded and inadequately funded. A gentler economic argument emerged: Poor women could simply not afford the thirty to fifty hours of pre- and postnatal care that the MCA deemed adequate. Mary Beard advocated for well-trained and supervised lay midwives, citing Scandinavia's example. But Alta Dines, speaking in her role as head of the Bureau of Nursing for the AICP, noted that public health nurses were in the perfect position to educate poor mothers in their homes about the importance of pre- and postnatal care. But, this kind of personalized care was always the first to be cut when agencies confronted tighter budgets.

Dines also took her discipline to task and echoed what was increasingly appearing in the nursing literature. Most nurses, she pointed out, did not like obstetrical nursing work as it was unpredictable, time-consuming, and labor-intensive. More damning was a 1931 brief report on the White House Conference on Child Health and Protection's Subcommittee on the Education of Nurses, which warned that there is "no escape from the conclusion that nurses do not know what adequate maternity care is."[54] And even the discipline's own *American Journal of Nursing* bluntly stated in a 1933 editorial that "mothers are dying because sick nurses are not taking proper precautions."[55] In the end, Dines concluded, "the nurse cannot be eliminated from taking her share in poor quality work."[56]

East Harlem's nurses did have additional maternity training even as it moved its program out of homes and into clinics. While its neighborhood maternal mortality statistics remained strong, its principled rationale for clinic-based work also had a more pragmatic base. Later, Grace Anderson would describe the years between 1933 and 1936 as a period of "retrenchment and consolidation." Even though the Rockefeller Foundation support remained constant, the average yearly income of the center had declined 23 percent. Some of this

decrease came from an inability to collect sliding-scale fees charged to patients in a time of great need. But the Milbank Memorial Fund also dropped its contribution to the teaching service by one-third in 1933, by another 12.5 percent in 1935; before raising it again to the 1933 level in 1936. For the first time, the Service found itself with a $5,000 deficit as it closed the 1935 fiscal year. In response, Anderson had to cut both nursing staff and staff salaries, consolidate the nutrition and parent education consultants' role into one position, and place Sybil Pease on part-time employment.[57]

Anderson also terminated the role of the Service's statistician to cover her budget gap. This was a large loss. Rather than research new problems such as reaching out to families most in need, the Service's public health nurses now published pamphlets more akin to policy and procedure manuals than hard data. These pamphlets were popular. Those such as the *East Harlem Health Workers Handbook on Infant Development, Care, and Training* (1932) or *What Every Family Health Worker Should Know* (1934) or the *Handbook on Child Care* (1937) provided public health nurses across the country with the physical and psychological assessment data; with the forms used to collect and order data; and with the pamphlets left with families for their continued education. These were a valuable and valued service to the discipline of public health nursing. But it turned the Service away from its mission of research.

These decisions were made to save the teaching service. It remained absolutely intact, continuing to serve approximately one hundred full-time, part-time, and visiting students throughout the years of "retrenchment and consolidation."[58] But a larger problem loomed. Rockefeller Foundation funding would end in 1936 and, despite concerted attempts to explore future sources of income from federal sources, including the new Social Security Act and other New Deal programs that supported public health nursing education, no alternatives presented themselves.[59] The fight to save the Service depended on getting the Foundation to change its mind.

The Fight to Save East Harlem

The fight to save the East Harlem Nursing Service, in general, and its teaching mission, in particular, fell to Mary Beard, who, after the reorganization, was the Foundation's associate director of the International Health Division, now the only division within the Foundation that had any interest in nursing. The IHD had been continuously supporting women who might assume leadership positions in the countries where the Foundation had made an investment in medical sciences and public health by awarding fellowships to study in the United States. The East Harlem Nursing Service, along with Vanderbilt's, Yale's, and

the University of Toronto's School of Nursing, had been consistently part of the fellowship experiences. The support of the IHD was critical.

First, Beard called a dinner meeting of the board of directors of the East Harlem Nursing and Health Service at the women-only Cosmopolitan Club on March 13, 1935. The discussion stretched past midnight, but the strategy for approaching Frederick Russell, the head of the IHD who had succeeded Pearce after his 1930 retirement, was finalized. Granted, Beard wrote Russell two days later, the Foundation had no interest in graduate education for public health nursing leaders, but sustaining the work of the East Harlem Nursing and Health Service was "one of those decisions which sometimes have to be made which are exceptions to the rules." It stood "head and shoulders" above any other teaching center. It was a far more superior developed practice field for public health nursing than, she emphasized, any of the schools of nursing in which the Foundation was interested, including the University of Toronto, a Foundation nursing favorite. It broke new ground in working to prevent mental illnesses through its family health teaching; and had "become the very kind of practice field which the IHD is attempting to foster all over the world."[60]

"Public health nurses," she continued, "cannot be educated without such a teaching field." But, keenly aware of the Foundation's aversion to fund any project that lacked independent sustainability, she tried to broker a compromise.[61] At present, she argued, there were no schools of nursing in the city sufficiently independent of hospital or medical school control that could absorb the graduate program at East Harlem. But in five years, she predicted, there would be. Right now, Teachers College and East Harlem represented the only counterweights to traditionally structured schools of nursing. But in five years and with an additional $90,000 grant from the Foundation, East Harlem could join the ever-strengthening Presbyterian and the New York Hospital Schools in their quest to offer postgraduate public health nursing education.[62]

Russell was, in fact, sympathetic to Beard's appeal and aware of the importance of the teaching service.[63] But Appleget, the Foundation's vice president, was less so. The Foundation officers debated the merits of all possibilities, including an affiliation with a proposed School of Public Health Nursing at Cornell, but such seemed "ambitious and complicated" and, as Cornell was now affiliated with the New York Hospital that had its own School of Nursing, not an option for the foreseeable future. On June 24, 1935, after repeated queries from Folks about the length of the deliberation, Appleget informed him that there would be no additional Foundation support. The Foundation would stay with its tradition and with the time-limited appropriation promised in 1932. The last grant of $10,000 would begin, as planned, on December 1, 1935

and end on November 30, 1936. He found himself unable to make any exceptions, no matter how worthy.[64]

Beard found it "most distressing" that this decision would leave the Service with only the pledged income from the four organizations that provided financial or in-kind nursing resources to it—certainly more than half of its budget, but leaving initiatives in mental health, nutrition, and parental education "crippled."[65] In December, she again approached the Foundation, suggesting $5,000 to maintain these services in 1937 and 1938 until a plan could be developed that would transfer the East Harlem teaching staff to a new city health center run by the New York Hospital–Cornell Medical Center.[66] The Foundation agreed to an additional year.[67] Beard then resigned from its board. "I feel I can serve East Harlem better," she wrote to Folks in January 1936, "by resigning from the Board than if I continue to be a member of it."[68]

The directors and staff of East Harlem refused to see this as the end of their grand experiment. By 1937, they had prepared extensive materials to publicize their work. The *East Harlem Nursing and Health Service: Fifteen Years of Cooperative Endeavor: Should It Go On?* carefully laid out the steps taken to achieve its "new approach to health work." Over the past fifteen years the Service had met the needs of the community for sick and maternity nursing. It had developed new services such as health work for preschool children. It experimented with the organization of nursing services. It had integrated knowledge from nutrition and mental hygiene into all aspects of health work. And it had brought the skills of a family caseworker to bear on common problems and trained a new generation of practitioners from across the globe. They had battled what they saw as the illiteracy, old-world customs, and fatalistic indifference of southern Italian immigrants, and now pointed with pride to how the now-adult children they served brought their own children to the Service. They felt they confronted what they believed other agencies knew but never publicly admitted: the often ignored fact that the families most in need of service were often those least likely to benefit from it and now more "consciously" selected parents most responsive to teaching and guidance. While they continued to attend to all families who experienced episodes of illness or the birth of a new child, "maximum help" was given to families of "more ability."

They also believed that there was now complete acceptance by both the public and other public health disciplines of the nurse as a "general practitioner" maintaining high standards of work that integrated the specialized services of sickness nursing, maternal and infant nursing, and tuberculosis nursing. The path had not been an easy one. Nor had they yet to claim complete success. The pull toward specialized knowledge in such particular areas as obstetrics, child

development, and infectious diseases had created awkward language both at East Harlem, in particular, and in public health nursing, in general, about the need to "generalize about a specialty" or to create a "modified generalist" in which one nurse might claim specialized knowledge even as she met all the needs of her neighborhood.[69] But the nurses at East Harlem claimed they had elided such problems. Through constant experimentation, a "new approach" to family health work had been achieved, they believed, that integrated the work of the visiting nurses of the seriously ill and new mothers with the approach of the "health" nurse that—using new knowledge from nutrition and mental hygiene—would continue to reduce the need for sickness care. The East Harlem Nursing Service drew a sharp distinction between its "new" work and that of a previous generation of public health nurses. Its work was based on the individual needs of individual families, not on initiatives that would affect the community as a whole.

And the data they presented indicated it worked. Over the fifteen years the Service worked with families, malnutrition in children declined from 26 percent of all children it saw to less than 4 percent in 1936. Infant mortality declined from seventy-one deaths in 1923 to fifty-six in 1935. With its successful immunization initiatives, diphtheria deaths had almost disappeared and the measles death rate had significantly declined. The Service added careful caveats to this data. Many other agencies, it acknowledged, worked in the district, and the constant and consistent availability of federal relief dollars put more food on families' tables than the inconsistent earnings of wage workers before 1929. Still, in their minds, the best data were less tangible. It took pride in the changed relationships that existed between its nurses and their families; in parents' increasing ability to work through many problems on their own; and on the Service's prominence as a "laboratory" for the training of public health nurses.[70]

There was still much to be done. They "deplored" the fact that a move into administration was the only way nurses could increase their salaries, and wanted to create a new "senior field worker" so that their best and most experienced nurses could remain in "direct family health service." They wanted their student service "relieved" of its "most serious handicap—the pressure of bedside nursing." Under the terms of its agreement with Teachers College, the students "cannot carry the acute work," and, with the commitment of the Service to generalized nursing, "the burden of this falls on the advisors."[71] They also wanted to strengthen its mission of experimentation and publication. And their colleagues in the wider public health nursing world agreed. All of the letters of support it marshaled in support of its continued existence spoke to this unique function of the Service. Katherine Tucker, now the director of the Department of

Nursing Education at the University of Pennsylvania, wanted the Service to turn to studies of school nursing—an area of practice in which she believed there was little evidence based on real study and experimentation.[72] Marguerite Wales, now a consultant in nursing education to the W. K. Kellogg Foundation, noted that nowhere else have specific problems in public health benefited from the group thinking of experts, not just thinking about but actually working to solve problems; and its publications were avidly read by nurses across the globe.[73]

But, ultimately, the fight failed. As Appleget reminded Folks in his final appeal for continued funding in November 1937, the IHD only worked with sustainable governmental agencies, not voluntary ones like East Harlem. Its uniqueness, in fact, was its problem. It was neither a city health service nor an affiliated unit of the "great medical centers." It was providing a "notable community service," but that which made it renowned also made it vulnerable. East Harlem had been, in his mind, "rather stubborn in its independence." And it had been. It had kept itself free from relationships with hospital-based schools of nursing whose inevitable and insatiable demands for service would have compromised its ability to identify, experiment with, and solve what it saw as problems uniquely within the domain of public health nursing. And it had steered clear of the politics of public health by not seeking a relationship with the city's Department of Health. As Katherine Tucker pointed out in her letter of support, it had fewer "entangling alliances" and never suffered from "the periodic upheavals that usually occur in most community services."[74] This, Appleget acknowledged, led to the excellent work of the Service—and to the question of survivability once the Foundation stopped the last remnants of its support in 1937.

Privately, criticisms of the East Harlem Nursing and Health Service emerged in public health nursing circles as word of the Rockefeller Foundation decision spread. In 1937, Katherine Faville, a Vassar training school graduate, the former dean of Wayne University in Detroit, and the new director of nursing at Henry Street's Visiting Nurse Service, wrote Anderson that planning for the future would remain problematic as it was never very influential in New York City itself. Raising money would be easier if it had data showing that it influenced practices at the city's Department of Health.[75] Nineteen thirty-eight was a very demoralizing year. Tensions between the Service and Maternity Center Association flared. Hazel Corbin wrote that she had carefully studied the Service's statistics over the past five years, and decided that the Service's work with pregnant mothers still left it "with a long way to go." The Service had failed to meet a goal of 75 percent of pregnant women engaged in prenatal care; and too many of these women used private hospitals with a "low standard of care." Anderson

countered with an argument that many of the mothers for whom the Service cared "bitterly resent their pregnancies," and too often saw neighbors having children easily and without scientific care. The nurses at East Harlem lived close to the lives of their parents and children and "can't avoid seeing their problems." Corbin retorted that she "could not help but smile" at Anderson's response. In MCA's experience "they are all people and their hopes and desires and ambitions and fears are the same, regardless of what class one might care to put them into."[76] And even the pool of potential students demurred. Mabelle Welch, the associate director of the Service, admitted "a lack of energy in the field." Not even nurses in postgraduate public health programs, she conceded, wanted the kind of advanced fieldwork training that East Harlem offered. These students largely preferred only classroom lectures, and if their program did require fieldwork, they approached it as a "necessary evil."[77]

The East Harlem Nursing and Health Service limped along with increasing deficits for the next few years. Slowly, and inexorably, participating organizations began withdrawing. MCA pulled out. The Henry Street Settlement and Visiting Nurse Society, always an ambivalent partner, decided it needed to cut its appropriation; the Milbank Memorial Fund could not continue its financial support "indefinitely." No other foundations, including the New York and the Carnegie Foundations, could find their way free to provide support; and the Department of Health had too great a dependence on federal relief dollars to even consider a contribution. Slowly, the Service reduced its staff. Grace Anderson took an extended leave to deal with her "serious heart condition." And Maybelle Welsh, her assistant, began working part-time for Teachers College.[78]

The Service finally acceded to the inevitable. It gave all remaining staff an additional month's pay and closed. A personal and rather terse letter to the Foundation in January 1941, from Margaret Nourse, the president of Saint Timothy's League and long-time supporter of the Service, acknowledged that "your generosity and real interest in this project entitles you to know of the imminent shutting down of this teaching centre [*sic*]."[79] An innovative and interdisciplinary Nursing Service and, as Nourse inadvertently emphasized, teaching service, that had hoped to transform the practice and curricular landscape of public health nursing now shared the fate of the earlier Health Center and had come to an end.