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Nursing with a Message

Patricia D'Antonio

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Not Enough to Be a Messenger

In the early 1920s, those who would reform the US healthcare system established a small series of demonstration projects that would provide patients access to high-quality, cost-effective, and expertly coordinated healthcare. Much like the goals of those supported by today's Center for Medicare and Medicaid Innovation, these demonstration projects would translate ideas into practices that could be easily adopted by existing healthcare structures. Many of the demonstration projects of the 1920s proved successful and many of the practices they supported proved enduring. They established the idea of a neighborhood health center as the most effective site of public health initiatives, an idea now institutionalized in the Affordable Care Act's expansion of monies for community health centers to bring high-quality care to poor urban neighborhoods and isolated rural ones.¹ They placed the practice of "periodic medical exams" for both children and adults as central to maintaining health and preventing illness. They set the stage for the eventual insurance coverage of exams such as mammography for women, prostate cancer screenings for men, and vision and hearing exams for children. They launched an emphasis on oral hygiene and dental care as key pillars in one's overall health status and, while availability of service remains less than ideal, an emerging field of research and practice in oral-systemic health holds the potential to alter this terrain.² These demonstrations, in fact, eventually established the current norms of primary care. And public health nurses played a critical role. They brought the messages of health into illness care even in the face of the often-suspicious communities they served. And they brought the norms of middle-class health practices to families excluded by the financial requirements of fee-for-service medicine.

More immediately, much good came from these demonstrations. The East Harlem Health Demonstration Project proved that its community sought health and welfare information when it was easily available to them. The East Harlem Nursing and Health Demonstration Project highlighted the importance of research in the public health nursing agenda. And the Bellevue-Yorkville Demonstration Project showed how public and private partnerships could be successful when carefully calibrated to meet the Department of Health's own mission and goals. Each provided different data streams that Shirley Wynne, New York City's commissioner of health, needed as he moved to implement a system of neighborhood health centers when federal construction dollars became available in the mid-1930s. Those involved in the demonstration projects constantly talked with one another and showed a certain nimbleness in stepping in to solve problems or provide resources that another lacked.

But notions of "coordination" and "cooperation" were, as contemporaries recognized, always easier to conceptualize than to implement. Michael Davis, the noted reformer, told nurses at the 1939 Annual Meeting of the National Organization for Public Health Nursing that these notions demanded "imagination and courage" rather than the "protective attitude" too often engendered by ideas for change. Despite massive federal involvement in providing health and welfare services during the Great Depression, there would still be a place, he continued, for smaller, private health agencies, like the East Harlem Nursing and Health Service. But he added an important caveat. To survive, he told public health nurses that they needed the "imagination to conceive, investigate, and define what unmet needs are" and the "courage to scrap past activities and work on that somewhat uncertain and often controversial borderline which runs between the present and the future."³

This borderline was an increasingly fraught space. Some of the tensions in this space, as historian Karen Buhler-Wilkerson has argued, did lie with a changing context. The closing of American borders to immigrants mitigated the need for a public health nurse to bring both "medicine and a message" of Americanization to poor families.⁴ Indeed, the poorest families now crowding New York City—those from Puerto Rico and blacks from southern states—already claimed American citizenship. But these claims were tenuous, complicated, and, preferably, ignored. In East Harlem, in particular, Puerto Rican families did not fit comfortably into an established, entrenched, and binary racial hierarchy. While some of the neighborhood's politicians and activists, including Leonard Covello, found ways to form alliances with members of the Puerto Rican community, most others kept their distance. Puerto Ricans, in turn, kept their distance from blacks as a strategy to fend off further marginalization.⁵

This created a toxic neighborhood stew that erupted in the 1935 Harlem Riot. Its historian, Jeffrey Stewart, described this as the “first modern race riot” in the United States and “symbolized that the optimism and hopefulness that had fueled the Harlem Renaissance had died.”⁶

And the Great Depression only exacerbated the increasingly common turn toward hospitals for childbirth and surgeries, especially those for infected tonsils and adenoids and appendicitis. Hospitals also treated accidents (an increasing problem on the crowded streets of New York City), emergencies, and cases of pneumonia, digestive diseases, and the “degenerative diseases” of middle-aged adults.⁷ Through the 1930s, the vast majority of these could still be managed in New York City homes, but the increasing depiction of urban apartments as small, crowded, and unsanitary created a pull toward the clean if not sterile environment of hospitals. Poorer families wanted what they saw middle-class families accessing and nurses encouraging, especially in childbirth. They, too, wanted healthcare moved out of their homes and into hospitals. And they needed this to happen, as well. Poor families, unable to afford private physician fees that would come with a home visit, turned to the city’s municipal hospitals and outpatient clinics. Overcrowding in hospitals was rampant; Bellevue Hospital, for example, reportedly operated at 110 percent of its capacity by 1933. And long lines were common in their outpatient clinics, especially as the “Depression poor”—those whose own standard of living had been decimated by unemployment—joined others in seeking what was often free care. “People went to hospitals,” historian Rosemary Stevens has argued about these institutions during the Great Depression, “expecting to be taken in.”⁸

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

rather than individuals. Yet their history also provides a cautionary message as we move forward to capitalize on the opportunities afforded by the Affordable Care Act (ACA) and the calls for proposals from the Center for Medicare and Medicaid Innovation. Disciplinary wishes—more specifically, the quest of public health nursing leadership for control over the education needed to enter their practice—cannot be separated from the needs of constituent communities.

Science and Social Justice

As historians Amy Fairchild, David Rosner, James Colgrove, Ronald Bayer, and Linda Fried have pointed out, the postwar turn to the “new science of public health” defined the field through the 1920s and 1930s. This new “science” took the laboratory’s seemingly unbiased data and the individual as its domain. It joined with the profoundly conservative political and social climate that also produced the sharp immigration restrictions that characterized changes in the East Harlem neighborhood.⁹ And, particularly at the Milbank Memorial Fund’s three demonstration sites across New York State, the fear of being accused of being “socialists” or “radicals” by members of the American Medical Association significantly tamped their enthusiasm for doing what they believed were the right things the communities needed. They knew, for example, that lay public health officials often had the most prescient vision of what the demonstrations might do for their particular communities. But, they decided, they could not afford to antagonize local general practitioners and always chose physicians to lead more conservative initiatives.¹⁰

New York City’s public health nurses were absolutely central to the success of this conservative and medicalized vision. They came to their support of this vision steeped in a training school tradition that had valorized medical science and medical knowledge not only as sources of truth but also as those of power and authority. Certainly, the site where they learned this knowledge—the hospitals that used their work to care for patients through their three-year diploma school experience—emphasized the kinds of knowledge needed for illness care. But it also shaped an enduring partnership in which nurses saw themselves as the “educated allies” of physicians and engaged in a more inclusive and more acceptable relationship with medical knowledge than that of women who would be physicians. White nurses would be assistants to powerful white men in ways that reaffirmed conventional gender and racial hierarchies.¹¹

Nowhere was this more evident than in New York City public health nurses’ embrace of the movement to ensure all mothers had medically supervised births in hospitals. Their almost embodied belief in the primacy of medicine and science took precedence over data about where and how mothers were

ding. But they did good as well. Public health nurses were also in homes and on the street encouraging families to immunize and vaccinate their children. They translated the science supporting the Schick test for diphtheria, the Wasserman for syphilis, or the Mantoux for tuberculosis into language that individuals, and parents in particular, could understand. New York City's public health nurses, steeped in a training school experience that valued their command of medical knowledge, embraced this new science. They wove it into the "message" they delivered with their medicines to families.

Yet, the mantra of mental hygiene remained enigmatic to many of these scientifically trained public health nurses. As they surveyed the new knowledge available in the interwar years, they chose that which resonated most strongly with their training school experiences. Much like many physicians who refused to incorporate exhortations to include periodic medical exams into their practices because it lay outside their own training, many public health nurses in New York City chose to incorporate knowledge into their practices that reinforced the familiar. The incorporation of mental hygiene, later renamed mental health, would come to nursing. But it had to await the post-World War II movement to reorient nursing practice in ways that emphasized the primacy of the individual and the nurse-patient relationship.¹²

Interestingly, medicine was the one public health discipline largely absent from the day-to-day considerations of these nurses and social workers at both the East Harlem and the Bellevue-Yorkville demonstration projects. Nurses nursed and social workers created "adjustments" in individuals and families with little attention to the politics of practice raging above them. Physicians, in fact, seemed more concerned about the practices of nurses and social workers than the nurses and social workers were about medicine's—about nurses' need to scrupulously follow their medical instructions and about social workers' need to be wary about providing material relief to a family who would use it to purchase a new automobile for Sunday drives into the country.¹³

In many respects, public health nurses had already worked through their disciplinary tensions with physicians. By the early 1920s, both public and private public health nurses worked under sets of "standing orders" from physicians that covered procedures in most routine cases of bedside nursing and health teaching. Changes to these orders were incremental and, most often, controversial. Bellevue-Yorkville's plans for changing established nurse and physician relationships were the most ambitious. It offered private medical practitioners in its demonstration area their own public health nurse to follow patients into their own homes both to ensure they followed medical directives and to enhance messages of health. Most physicians refused this offer.¹⁴

But if these tensions had been resolved, those with newly emerging public health workers had not. Public health roles for nutritionists and health educators had emerged in the 1920s, but these roles, and the individuals in these roles, never seemed of concern to the city's public health nurses' deliberations: Nutritionists were too small in number; and health educators took groups in the community as their domain. Social workers who, as did nurses, took individual families as their community of interest, represented the greatest threat. But public health nurses, both in New York City and across the country, vanquished that threat with relative ease. They capitalized on the relative trust they had built with families and laid claim to their tradition as the only group of women health workers with legitimate claims to specialized medical knowledge.

But this victory had its own costs. Public health nurses joined others in turning toward science and away from what had been an earlier generation's robust sense of social justice. They were not alone. By 1934, Homer Folks found himself "disturbed" that the Milbank Memorial Fund's advisors were steering it into fields of "medical economics" and away from direct clinical initiatives in public health. He brooked no concessions when challenging the assertion that medical economics, particularly those concerning implementing some of the recommendations from the Fund-supported Committee on the Costs of Medical Care, were indeed related to public health.¹⁵ And eventually even the venerable Henry Street Settlement and its Visiting Nurse Service had to separate into two autonomous organizations. By 1944, no one public health worker—whether she was a nurse or social worker—could maintain Lillian Wald's vision of health and social justice for communities in need.¹⁶

The experiences of public health nurses in New York City's health demonstrations do remind clinicians, in general, and nurses, in particular, that it is "not enough to be a messenger" of physical health and mental well-being. Decoupling messages of health from the material conditions that make health possible—from education, from housing, from gainful employment—creates a hollow message that, as other scholars have pointed out, inevitably blames victims for their ability or inability to make changes in their lives. But this story sharpens this message. Nurses were not immune to the effects of the complicated and intersecting domains of race, class, and gender. And within segregated race communities, class mattered most to both white and black public health nurses. It was not the only factor. In the 1920s, at the beginning of the health demonstration projects, both white Italian and black West Indian families could make legitimate assimilation claims on the health and social welfare agencies dedicated to both material relief and the process of Americanization. These claims gave these families the opportunity to accumulate resources



Figure 6. A Puerto Rican Family in the East Harlem Nursing and Health Service's Care

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necessary to move away from their traditional urban neighborhoods into more suburban ones. Those families that followed them into the neighborhoods of the demonstration projects—those from Puerto Rico and the American South—occupied a more complicated social space with ambiguous assimilation claims, tenuous citizenship rights, and little access to the changing levers of political power. Moreover, they moved into a public health system that had severed the links between their health and their environments.

But both white and black nurses struggled to reach the Puerto Rican families in East Harlem and the southern ones in Columbus Hill. Their frame of assimilation and aspiration had disappeared. As significantly, both groups of

middle-class women unwittingly reflected and refracted the nativist and racist assumptions pervasive in the conservative interwar years. They both believed their new constituents were unable to assimilate to, if not American standards, then to middle-class norms. This, too, is one legacy that New York City's public health nurses helped create in supporting a medicalized model of public health that incorporated prevailing social assumptions. But, with the full implementation of the Affordable Care Act—and especially as issues of access to prenatal care, poor maternal health outcomes, and efforts to reach preschool children remain problematic—we may be given another opportunity to recouple health with its social determinants for all in need.

Constituent Need and Disciplinary Interests

In many respects, the public health nursing leaders involved in New York City's health demonstration projects achieved all their disciplinary ambitions. They saw a 1923 Report of the Committee for the Study of Nursing Education enshrine their standards for nursing education first in the United States and then, a short while later, abroad. They celebrated the establishment of a separate Bureau of Nursing in the city's Health Department and the fact that, for the first time in the city's history, a nurse and not a physician supervised the practices of other public health nurses. They were among the pioneers of a "new approach to health work" that brought families into their disciplinary domain. Certainly, they never achieved the Rockefeller Foundation's goal of uniting public and private public health nursing agencies, but, in fact, these public health nurses never shared this agenda. They believed in the value of private agencies, like the Henry Street Settlement, to set the standards for quality and innovation that the city's own public health nursing bureau would soon follow. They considered that the Foundation had failed them in refusing to support East Harlem's postgraduate teaching mission rather than that they had failed the Foundation.

Yet, in the end, the East Harlem Nursing and Health Service's commitment to take practice and teaching as its explicit domains in 1928 held the seeds of its eventual failure. It may have met the needs of many of its patients, but it served the needs of a discipline looking to create well-educated public health nurses. The Service, in fact, lost its way when it became enamored with its teaching mission. Rather than performing research on new problems such as how to reach out to families most in need, it now published pamphlets more akin to policy and procedure manuals than hard data. These pamphlets provided public health nurses across the country with the physical and psychological assessment data collected by the Service's nurses; 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 they reflected little innovation. Rather, they reflected the practices of the more progressive Visiting Nurse Associations in New York, Boston, Chicago, St. Louis, Toronto, and Baltimore. And they reflected little of the changing healthcare landscape, including the increasingly prominent place that cancer, heart disease, venereal disease, and chronic disease now had on the public health agenda.

Indeed, the eyes of the nurses at East Harlem were on what they believed their constituent families needed rather than on how they understood what these families wanted. They decided to restrict their practice during the financial turmoil of the 1930s to only the more receptive families in their neighborhood and shut themselves off from others who, in all likelihood, may have needed them the most. It closed itself to the voices of other constituents in its community. And it reinforced the discipline's own insularity.

East Harlem did try to find alternative sources of funding for its practice and teaching mission. At a 1934 meeting of the East Harlem Council of Social Agencies, Grace Anderson of the East Harlem Nursing and Health Service declared that if the poor were to receive the help they needed, the city would have to move beyond merely creating health centers. It needed to provide the same subsidies to home nursing as it currently did to health centers and municipal hospitals. These subsidies for "home relief," she argued, were as "legitimate a charge to the taxpayer as hospitals."¹⁷ Anderson was not alone in this wish; she only echoed the hopes of leading public health nurses across the United States. These kinds of subsidies never materialized. Rather, Anderson's hope of municipal funding to preserve sick nursing and health promotion in the home reflected healthcare as progressive public health nurses wanted it to be. They wanted it to remain constructed within intimate personal relationships forged in homes and not in the more impersonal ones found in the central hospitals and healthcare centers that increasingly dominated the healthcare landscape.¹⁸

In the end, these demonstration projects have also left some unanswered questions that we may now have the opportunity to address in the Center for Medicare and Medicare Innovation's calls for its own demonstration projects. The collapse of initiatives in the early 1930s to investigate the kind of worker or team of workers to best deliver public health services at the point of contact with those in need has left fundamentally important ideas unexplored. The disciplinary domains of nursing and social work—domains first forged in hospitals—may not map cleanly onto the geographies of public health. And the tensions and conflicts that existed between these disciplines may be

emblematic of struggles to assert dominance in a hierarchical public healthcare structure led by medicine. Or they may represent points of disconnect between what the disciplines wanted to do (and were prepared to do) and what their families needed. Certainly, we do see the rise of formal “health educators” in the 1930s, and the creation of roles for lay “community health workers” in the 1960s. But these newer public health roles remain layered upon a public health structure built around the joining of the disciplines of nursing and medicine that has had little sustained examination.

And the paradox of prevention remains. The ability to shift an entire community or population to behaviors widely acknowledged as healthier still remains highly problematic and contested. The day-to-day practices of public health nurses do lack the drama, the intensity, and the technology that sustain a community’s interest. Yet, nurses in the community reached the community in ways that other disciplines could not and did not. The widely recognized and respected validity of their knowledge claims, in fact, situated nurses at the center of a matrix of competing public health agendas. The champions of a new public health science, the foundations that supported the demonstration projects, the families they served, and the other disciplines with which they worked all had ideas and projects that they believed nurses were particularly situated to implement. In some ways, the experiences of nurses in New York City’s health demonstration projects suggest the paradox of prevention is as much about power as it is about policy. The experiences of nurses in New York City’s demonstration projects suggest a process of constant negotiations around the ability to set, implement, limit, and financially support a health as well as well as an illness agenda.

As important, the nurses in New York City’s demonstration projects added their own disciplinary agenda to this process. Their intent was to situate themselves at the nexus of independent, interdisciplinary, and instructional nursing practices. In many respects, these nurses were successful. Those at Bellevue-Yorkville achieved disciplinary independence when nurses, rather than physicians, obtained control of public health nursing practice; and those at the East Harlem Nursing and Health Service established an innovative teaching service that remained the envy of progressive public health nursing educators throughout the country. But East Harlem’s critics were correct. Without alliances—however problematic—with either a school of nursing or the city’s own Department of Health, East Harlem nurses had no formal power to press for health. Their independence had a steep price.

Closely examining the power of nurses to shape public health practices in the interwar years also calls attention to the influence of the less tangible goals,

needs, and ambitions of the many different constituents that conceptualized, paid for, delivered, and received healthcare services. As the story of health demonstration projects in New York City illustrates, these goals, needs, and ambitions were as critically important drivers of ultimate success or failure as the theoretical underpinnings that led to their creation. These drivers—the tensions between public and private responsibility for setting public healthcare agendas; between lofty aspirations of coordinated care and the realities of not wanting to cede to a controlling authority; between the hopes of a discipline and the requirements of its community; between public healthcare as nurses wanted it to be and the healthcare landscape that actually existed—were as important in the health demonstration projects in New York City as were the clinical and economic metrics measured. The experiences of the East Harlem Nursing and Health Service stand as a seminal example. The Service gained international fame among public health leaders for its innovative and independent nursing practice and research. Yet it ultimately failed because its commitment was to a particular disciplinary mission that did not meet the needs of the constituent communities it served. From 1928 until its closing in 1941, the Service focused more on the educational advancement of public health nursing and less on addressing the real, changing healthcare needs of those in its East Harlem home. For all its successes, it also provides a cautionary tale as we consider the multifaceted dimensions of the clinical experiments that will be part of the Innovation Center's demonstrations in comprehensive, high-quality, and coordinated care.

Finally, the experiences of public health nurses as they sought to capitalize on changes in the public healthcare landscape in 1920s and 1930s New York City suggests that we need to have sustained debates about the educational and the regulatory frameworks that structure the practices of a “new kind of messenger.” The issues are not that dissimilar. Public health practitioners still speak of interprofessional practices, community partnerships, the new epidemic of chronic diseases and the resurging one of infectious diseases. And the dialogue has already begun. In 2010, the *Lancet*, one of the most influential medical journals across the globe, had already called attention to the “social construction” of our current division of labor among public health professionals in its landmark call for transforming conventional educational structures for an increasingly interdependent world.¹⁹ And the Institute of Medicine's *Future of Nursing* has most recently argued that nurses, in concert with other disciplines, need to reconceptualize their roles as health coaches and system innovators.²⁰ As the experiences of nurses in New York City's health demonstration projects illustrate, this dialogue cannot take place without a keen assessment of how the

national healthcare landscape will change in the context of the Affordable Care Act and of how the global one will be transformed as the world becomes more interconnected and interdependent. Yet it will not be easy. However much we value the idea of high-quality, coordinated care, the history of health demonstration projects in New York City illustrates just how hard that can be when different disciplines, organizations, and associations have a vested interest in attending to their own advancement, place, and power as they legitimately search for better ways to care for the people in their care.

As the Center for Medicare and Medicaid Innovation continues to issue calls to test best practice models to increase access to high-quality, cost-effective, and coordinated healthcare, we should see them as an opportunity to reengage with the unanswered questions of these earlier demonstrations. This is the moment to consider what is core to the different public health disciplines and what can be shared with others. And this is the moment to remember that ideas engender change, but the prerogatives of gender, class, religion, and disciplinary interests shape their implementation. As nursing develops potentially exciting projects that can be “scaled up” to serve even more constituents, we might also remember that the processes and politics of practice remain critically important. The notion of “coordination” among different disciplines is very challenging to operationalize. But we now have another chance to do so.