Nursing with a Message
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Public health reformers had every reason for optimism at the dawn of the 1920s. Two seminal events had set grand plans in motion. The first, the decision of the American Red Cross (ARC) that its newly reconfigured peace-time mission would concentrate on the more effective organization of health and social services through neighborhood health centers, promised to solve the knotty problem of care coordination among the myriad of public and private entities operating in large urban areas like New York City. The second, the release of data from the Metropolitan Life Insurance Company’s intensive tuberculosis (TB) case finding and treating study in Framingham, Massachusetts, suggested a direct path to bring the “white plague” under control at last.

Yet, New York City’s leading public health nurses looked askance at the developing plans to establish the city’s own health center and to eradicate tuberculosis—at least as it involved them. They believed they had already solved their discipline’s organizational issues with a private system that brought bedside nursing and health teaching to the individual homes of the sick poor and a public system that provided broader communities with health education, immunizations, communicable disease control and quarantines, and the oversight of the health of school-aged children. The city’s Henry Street Settlement and Visiting Nurse Service (VNS) was world-renowned for its ability to bring “medicine and a message” of health and American values into the homes of working-class and immigrant families. Its Department of Health, under the tutelage of Lillian Wald, the founder of Henry Street, had the first and now had the largest numbers of nurses working with children in the city’s schools.¹
This chapter maps the social, political, and public health landscape of New York City as it planned to meet these challenges in the aftermath of the First World War. It explores how a small group of white, middle-class, and well-educated public health nursing leaders worked among themselves and with other reformers to consolidate the disciplinary power they gained in their effective work bringing “medicine and a message” of American values to the working, poor, and often immigrant families they served prior to the war. It situates these women within the compromise brokered between public health and private medicine. Bruising battles between public health reformers and representatives of medical practitioners had established firm boundaries regarding who should treat the poor. Those nurses working in public agencies in large urban areas could only teach mothers and children about health and only rarely provided actual home bedside nursing care. In New York City, those working for private agencies like the VNS, the Association for Improving the Conditions of the Poor (AICP), and the Maternity Center Association (MCA) had more latitude. They provided bedside nursing care to sick individuals and prenatal care to mothers even as they taught their families the principles of health and hygiene. They also had a history of strong financial support from the Rockefeller Foundation.

Yet, like their colleagues in other large urban cities, these nurses worked within a complicated matrix that also supported the work of hundreds of other public health nurses employed by small, private neighborhood settlement houses, churches, welfare associations, and community organizations in the city. The proliferation of such agencies across the United States drove the national postwar emphasis on care coordination as a central element of the ARC’s commitment to health demonstration projects. In New York City, the problem of so many clinicians working to solve the same kinds of problems brought together the same prominent male social workers and sympathetic physicians to consult with the Rockefeller Foundation and the Milbank Memorial Fund. They successfully found Foundation funding to create a community-based health center in the East Harlem neighborhood of the city that could more efficiently coordinate the delivery of health and social welfare services to those in need; and they dreamed with the Fund’s officers of constructing a “monumental enterprise” in the Bellevue-Yorkville districts of the city that would eradicate TB, compel the attention of “scientific men,” and force action among communities of voters that seemed far too complacent about the need to increase tax dollars to pay for public healthcare.

The city’s leading public health nurses were not invited to these philanthropic tables, although they were aware of the plans. On the one hand, this
omission reeked of the privilege of alliances among powerful white men who were comfortable in viewing public health nurses as the veritable foot soldiers of their reform army. But it also kept at a distance those who were not engaged in their vision. Lillian Wald, the most powerful nursing leader in the city, if not the world, wanted no part of any planned demonstration either at East Harlem or Bellevue-Yorkville. East Harlem seemed particularly troubling. In addition to demonstrating the value of health and social welfare, the second demonstration that involved nurses would be one of care control. The East Harlem Nursing and Health Demonstration Project intended to pool all neighborhood nursing personnel and financial resources into one centralized organization to reduce nursing redundancies and clinical overlaps.

Wald and her public health nursing colleagues centered at the VNS felt quite comfortable ignoring the plans of other public health reformers. They believed themselves to be very secure in the putative empire they had built in New York City, an empire created by well-educated nurses adhering to the highest public health nursing standards when nursing the sick poor in their homes. But they were well aware that their nurses were an anomaly, not the norm. Wald and her colleagues were preoccupied with issues surrounding the education for practice of all public health nurses, not public health practice itself.

**Planning for Nursing**

Both contemporaries and historians recognized New York City’s place at the epicenter of the public health world in the aftermath of the First World War. Under the prewar leadership of Hermann M. Biggs, the city attracted international attention for its school health, immunization, tuberculosis, scientific laboratories, and clean milk reform initiatives. They also recognized the city’s place at the epicenter of the nursing world. Service institutions such as the VNS at Henry Street and educational initiatives such as those at Teachers College at Columbia University attracted and trained public health nursing leaders from around the globe.²

But for all its successes, postwar New York City still faced seemingly intractable health issues among its poor, working-class, and immigrant families—those most vulnerable to the rising costs of living in the postwar city, labor strikes, and, as the Department of Health reported, the “unstable economic conditions.”³ These health issues included high infant mortality rates, poor prenatal care, and insufficient attention to the prevention and treatment of tuberculosis. Established philanthropies, such as the venerable AICP, the largest and most influential private social service organization in New York City, provided important financial and social welfare assistance to the city’s
own public health initiatives, particularly for families that included a member with tuberculosis. All New York City public health leaders clearly understood the relationships among the conditions in which families lived, the material resources available to them, the access to education available to their children, and their health status. But issues of access and equity to the essential social and health services necessary to allow mothers to raise healthy infants, to help children achieve in school, and to enable breadwinners to remain productive at work remained highly problematic.

The city’s nursing leadership, joined by other public health reformers, believed they had another, more vexing, problem to solve in the early 1920s: how would middle-class families who needed care be nursed? In New York City, as in other parts of the country, the working and immigrant poor had access to the services of privately funded visiting nurse services who sent skilled nurses into their homes for short, often daily visits and charged fees that were heavily subsidized by donors. The rich had access to private-duty nurses, graduates of hospital-based training schools, who stayed by their patients’ bedsides for the entire illness experience and charged concomitantly higher fees that were beyond the reach of most middle-class Americans. As one commentator noted in 1921, “the great problem” is “the problem of providing adequate nursing service for the community at a rate within the means of those who must pay for such services.”

Ideas for solving this problem abounded: Have visiting nurse societies engage in the “hourly nursing” of middle-class families at rates greater than those charged the poor but less than the cost of continuous private-duty nursing; have nursing registries—employment agencies that matched a family in need of service with a private-duty nurse in need of work—seek opportunities for nurses who wanted less than continuous employment at prorated fees less than that usually charged; and, to the chagrin of nursing leaders, create a new category of a subsidiary nurse or nurse attendant who had a much shorter period of training.

But in New York City there was cause for some optimism. Nurses Annie Goodrich, who had become head of Henry Street, and Anne Stevens of the Maternity Center Association proposed yet another alternative. They turned to two allies and strong supporters of nursing at the Metropolitan Life Insurance (MLI) Company, Lee Frankel and Louis Dublin. Frankel, the vice president of the company’s industrial insurance division, had a long-standing history of collaboration with Lillian Wald at her Henry Street Settlement and Visiting Nurse Service in the early decades of the twentieth century. Wald, known for her innovative approaches to public health nursing, had identified the possibilities of MLI’s “penny policies” that—for the penny a week collected door to door, a price within the budget of working-class New Yorkers—policyholders would
be eligible for a death benefit that covered funeral expenses. In 1909, Wald had proposed inclusion of an additional benefit. When a policyholder or covered member of his family became ill, Wald would send one of her Henry Street visiting nurses into the home to provide the bedside nursing that could well be life-saving. Dublin was the MLI statistician who proved she was correct. Such nursing both saved lives (and—at 50 cents per visit—supported some of the operating costs of Henry Street) and decreased the dollars in death benefits the company would normally pay. By 1920, such policies had spread like wildfire throughout the country and within the insurance industry itself. Goodrich and Stevens proposed what was essentially a similar, private insurance program, but now for middle-class Americans, that would cover the costs of nursing care.7

The proposed Citizen’s Health Protective Society’s plan would also be much like prevailing mutual aid societies. These societies charged yearly dues and promised families help with medical bills when a member was ill and, most importantly, assistance with funeral expenses if the individual died. Like mutual aid societies, the goal of the Citizen’s Health Protective Society was to eventually become a self-reliant, self-governing entity run by its members. But, unlike mutual aid societies, the Citizen’s Health Protective Society would help with the costs of health, not illness care, and with the costs of nursing, not medical services. Its ambitious goals were to “work out” a self-supporting nursing service “within the means of the middle class.” Concretely, it would provide for the care of pregnant women, assistance at their delivery, and health work with their children until they reached school age. It would also arrange for a visiting nurse to provide bedside nursing when any member became ill. Dues would be $6 each year for an individual and $16 per year for a family.

By 1922, the nurses and their advisors had selected the Manhattanville neighborhood of the city, in the northwest section, from 122nd Street to 142nd Street and from 8th Avenue to the Hudson River because it was a “largely self-supporting neighborhood, not foreign in character and where the vital statistics conform closely to the general average of the city.” Manhattanville, in other words, was quite different from the poor, immigrant, and working-class neighborhoods that Henry Street nurses typically served in other Manhattan neighborhoods. It would allow nurses to broaden their reach to a white, middle-class constituency, who lived in newer apartments rather than older tenements, and who were young and newly married and ready to start their families. With the support of an anonymous philanthropist, the new Citizen’s Health Protective Society hired its director and set up its office in the heart of the neighborhood. Do you want, it now asked in handouts distributed to the community, a self-supporting nursing and health service?”
At the same time, New York City’s public health nursing leaders joined others across the United States in seeking answers to what they believed an equally vexing problem: What kind of education did nurses need for public health nursing practice? By the early 1920s, all nurses received their pre-licensure education in hospital-controlled training schools that depended largely on student labor for the care of patients. There, women traded three years of work on the inpatient wards for the knowledge, the clinical opportunities, the diploma they received at graduation, and, if they so chose, the right to sit for state licensing exams and earn the title of “registered nurse.”

This training school experience emphasized medical science, skilled techniques, and discipline. Training school experiences varied widely even within New York City. At its worst it meant negligible time in lecture halls, absurdly strict discipline, blind loyalty, and rote obedience. But at its best—and New York City was home to some of the best (albeit segregated) training schools for both white and black nurses in the country—the experience provided the medical knowledge and the training that nurses needed to confront the most persistent challenge to their authority: mothers, drawing on their personal knowledge of their family members in their own homes. Medical knowledge—drawn from the new tenets of exciting developments in bacteriology, microbiology, physiology, and chemistry and learned in a hospital space far from the domestic spaces where they would eventually practice—invited women who would train as nurses to invest themselves with an objective and scientific authority that would more effectively compete with mothers’ more personalized and often quite powerful knowledge claims in both the tenements and the drawing rooms of New York City.

Yet, this education and training was for the care of the acutely ill, those recovering from surgeries, trauma victims, birthing mothers, those who required convalescent diets, and, sometimes, sick children. It prepared nurses reasonably well to take care of the sick in their own homes. But it left nurses ill-equipped to do the rest of the work of public health nursing in the early 1920s: to persuade parents to adhere to quarantines if their child had a communicable disease; to monitor the health status of newborn infants at high risk of dying in their first month; to chart the normal development of young children at the baby milk stations where they also received fresh milk; to monitor the status of patients with tuberculosis who lived with their families; and to check for “defects” in the eyes, ears, nose, and throats of school-aged children. Some of New York City’s own private and public health nursing agencies had developed their own postgraduate public health nursing training programs for their staff; and a few private and public universities across the United States had begun to develop postgraduate
certificate or degree programs to provide classroom content on such topics as methods of organizing and administering public health nursing practices, sanitation, modern social problems, legal and legislative issues, and the knowledge needed for specialized practices in tuberculosis, child welfare, school, and mental hygiene nursing. But, in the eyes of public health nursing leaders, there were too few properly prepared public health nurses and too many, in New York City and across the United States, who held their positions because of rampant political patronage in municipal, county, and state public health systems.

Although preoccupied as a liberal voice in postwar national and international debates over politics, health, and social welfare in an increasingly conservative and nativist United States, Lillian Wald remained the most influential consultant on all matters related to public health nursing in the city and the country. Through her work at Henry Street, Wald cultivated a small group of nursing reformers who shared her vision for both nursing and the health of the community. One of the other leading voices in the campaign to better prepare nurses for public health nursing practice was Annie Goodrich. Goodrich, born into a prominent Connecticut family, had never dreamed of becoming a nurse, but traveled one familiar path into practice. Faced with her family’s declining fortune and health, she had entered the New York Hospital’s Training School for Nurses in 1890, when Wald was a senior. After graduation she had served as a staunch reform-minded superintendent of several prominent New York City training schools as well as New York State’s inspector of nurse training schools, and as a lecturer at Teachers College.

During the First World War, Goodrich and like-minded colleagues orchestrated a major victory for the discipline. As historians have long argued, nursing sick and wounded soldiers had been the only formal way that women could experience war as patriots and citizens. And many American women wanted to serve their country as willing albeit untrained nurses. Recognizing legitimate reports of shortages of trained nurses to care for sick and wounded soldiers—and alarmed by suggestions that the military might turn to well-educated but very quickly trained women volunteer nurses as had England—she campaigned for the establishment of the Army School of Nursing in Washington, DC. The army could meet its shortage by training its own nurses. Goodrich succeeded. And, as the war drew to an end, Goodrich took her place as the inaugural director of the Army School of Nursing in 1918. When the school seemed well established, she returned to Henry Street in 1919 to better manage the day-to-day organization of its VNS.

M. Adelaide Nutting, a music teacher in her native Canada, joined Goodrich in the campaign to reform nursing education. Nutting’s path into nursing was
another familiar one. Dissatisfied with teaching, she followed other Canadians—
drawn by the practice of their famous compatriot Dr. William Osler—to the
prestigious Johns Hopkins Hospital Training School for Nurses in Baltimore,
Maryland. Nutting had risen to the position of superintendent of nursing and
director of its training school by 1895. She had also participated in several semi-
nal events that marked the beginning of the drive to professionalize the dis-
циплe: notably, the formation of what would later be renamed the National
League for Nursing Education (NLNE) in 1893, and then the American Nurses
Association in 1896. She had come to New York City in 1907, holding the first
endowed chair in nursing in the country at Columbia University’s Teachers Col-
lege and beginning her long-standing tenure on the board of the Henry Street
Settlement and Visiting Nurse Service. And Nutting was fresh from her own
World War I victory. She had worked with Vassar College to establish a summer
training camp for women college graduates who wanted to contribute to the war
as nurses. These women traveled to Poughkeepsie, New York, in the summer of
1918 for an intense immersion in the sciences and public health taught by leading
authorities in the field. As the summer closed, these students were sent to
participating training schools for the remainder of their clinical experiences.16

New York City’s nursing leaders also forged strong links with others out-
side their Henry Street orbit. Lillian Clayton, a 1911 graduate of the nursing
program at Teachers College, past president of the NLNE, and current director
do the training school at the Philadelphia General Hospital, was one such con-
fidant. Clayton, one of the most respected directors of nurse training schools
in the country, found hospital support for moving beyond total reliance on
students for all patient care and had hired some graduate-trained nurses. She
had begun the process of reshaping class and clinical experiences so that her
students had more formal preparation before they entered the hospital’s wards.
And she worked to develop visiting nursing experiences for some of her inter-
ested and talented senior students.17

Yet, Mary Beard was the most influential of Wald’s circle of nursing reform-
ers. Beard, then the director of Boston’s Instructive District Nursing Associa-
tion, had built her visiting nursing service into one of the largest associations in
the country, rivaling only Henry Street in its scope, innovation, and effective-
ness. Beard also built ties to the Rockefeller Foundation during her tenure as
president of the National Organization for Public Health Nursing. She had been
subsequently invited by the Foundation to join Wald, Goodrich, Nutting, and
Clayton on the board of directors advising Josephine Goldmark, a progressive
labor activist who also lived at Henry Street, in her Foundation-funded inaugu-
ral survey of nursing and nursing education in the United States.18
This survey, originally commissioned to study the education needed for public health nursing practice by a Foundation with a deep interest in the important role public health nurses played in its own public health and medical education philanthropies, had been planned before the war. Wartime exigencies had forced its postponement. But at a 1920 meeting to discuss reviving the plans, Foundation officials heard Nutting’s plea for an enlarged scope of the study. Nutting wanted nothing less than “a serious and thorough study of the entire system of nursing education.” They also heard from Herbert Mills, a Vassar professor deeply involved with construction and implementation of the summer training camp, who spoke in support of a broader scope. His own college graduates, he told Foundation officials, complained “bitterly of hard work and long hours” when they left the camp and entered training schools.19 A consensus emerged rather quickly. There would now be two reports contained in the one formal survey: the first on public health nursing, in particular, and the second on pre-licensure nursing education, in general. American nursing leaders awaited the report, due in 1923, with baited breath. They anticipated the report would do for nursing education what the Carnegie Foundation–funded report on Medical Education in the United States and Canada had seemingly done for physicians when it was released in 1910.20 These nurses hoped this upcoming report would completely transform nursing’s educational landscape.

Planning for New York City

At the same time, the American Red Cross had decided that its newly reconfigured peacetime mission would concentrate on the more effective coordination of available social and health services in areas where they already existed; and in the development of new ones in more poorly served parts of the country. It charged local chapters with bringing together community leaders in government, philanthropy, and business to create carefully constructed and coordinated “health centers” that would best serve the needs of defined constituents. In Boston, for example, the city’s health department took the lead in establishing the Blossom Street Health Unit for the North End’s predominately eastern and southern European immigrant families. With the financial help of philanthropist George Robert White, it brought together the city’s private Community Health Association (a new name for its own visiting nurse service), the Family Welfare Society, the Catholic Charitable Bureau, and the Associated Jewish Philanthropies in one building for more effective social service and healthcare coordination. On the other side of the country, in another example, the vast Los Angeles County decentralized its health department and encouraged more
rural areas to test different ways of providing easier social service and health-care access to the Mexican and black families they served.\textsuperscript{21}

And preliminary data from the Community Health and Tuberculosis Demonstration Study that had begun in 1916 in Framingham, Massachusetts, suggested that early and intensive case finding and treatment decreased overall tuberculosis mortality. The Framingham Study, set in a small community west of Boston, started with all the elements of success. It was a “typical community” of second- and third-generation white Irish Americans, whose immigrant population of 27 percent mirrored that of the United States as a whole. Moreover, it had a supportive and engaged citizenship, a strong public health infrastructure, and a group of private medical practitioners who welcomed the use of the resources and laboratories available through the Study. It had set an ambitious goal: acknowledging the declining rates of TB throughout the United States, it intended to bring death rates to the aspirational rate of 30 per 100,000 at a time when similar communities were experiencing those approximating 121. It brought nurses into the town to canvas its men, women, and children in homes, schools, and workplaces. It offered expert consultative services to local medical practitioners, treatment in one of Massachusetts’s TB sanatoria, and, what most families preferred, treatment at home under strict public health nursing supervision. The Study met its goals. But questions remained. Was Framingham truly typical? What role did rising standards of living play in declining TB mortality? And, most important to Bailey Barton Burritt, the general director of the Association for Improving the Conditions of the Poor (AICP) and an influential voice among New York City social reformers, how did the results of the Study support his own idea about the importance of a “home hospital”? Beginning in 1912, the AICP in collaboration with the city’s Department of Health had challenged the orthodoxy of hospitalizing those with tuberculosis and, instead, rented an apartment building for a demonstration of the effectiveness of keeping families intact, with decent housing and nutritional support, and under strict public health nursing supervision. The small demonstration collapsed during the war when the city withdrew its funding. But Burritt’s dream lived on.\textsuperscript{22}

Burritt, educated at Columbia University, was a key member of a small group of New York City’s public health reformers who shared interlocking ties of class, gender, race, and progressive vision. He served on the committee advising the nurses’ Citizen’s Health Protective Society. But he was most active in providing the initial leadership of plans for the city’s response to the ARC call and the Framingham Study data. He had been appointed to the general director’s position of the AICP in 1914 at a time when Albert Milbank, president of
the Milbank Memorial Fund, served on its board. The AICP had groomed John Kingsbury and Harry Hopkins early in their social work careers: Kingsbury, also Columbia-educated, had served with the American Red Cross in postwar France and just been appointed as the executive secretary of the Fund, and Harry Hopkins, then drafting the charter for the American Association of Social Workers and soon to be its president, would later return to New York City to direct the Fund’s own demonstration projects before leaving to develop many signature New Deal programs.21

Under Burritt’s leadership, the AICP also played a key role as a mediator between private philanthropy and public health. And it had experience doing so in health work. Before the war, the National League on Urban Conditions among Negros, the forerunner to the National Urban League, documented unprecedentedly high mortality rates among the residents of the Columbus Hill section of the city, a black tenement neighborhood between Amsterdam Avenue and West End Avenue, and 59th Street to 65th Street. The League, headquartered in New York City, championed the cause of black social welfare by black social workers.24 But its expansive definition of social welfare also included the way some black nurses saw themselves. Adah Thoms, an 1895 graduate and then acting director of nursing at the black Lincoln Hospital Training School for Nurses, served as the League’s secretary. Thoms received postgraduate training in public health nursing at Henry Street and in social work at the New York School of Social Work.25 She was one of the most influential nurses in both New York City and the country. Edwin Embree, in charge of the nursing portfolio at the Rockefeller Foundation, recognized her training school as “one of the three first-rate negro training schools in the country,” and Thoms as an “excellent chief.”26 The norms of segregation in New York City did allow her access to the best postgraduate education, albeit for work in her own community of color. But it excluded her from the inner circles of nursing leadership and barred her from ever holding more than an acting director title at a school that she, in fact, actively led.

In response, and in keeping with the city’s commitment to health within a segregated system, Haven Emerson, then the city’s commissioner of health, asked the AICP to begin health work in the Columbus Hill neighborhood. In 1916, Burritt brokered funding from a small, private philanthropy in Westchester County, New York, and set Clara Price, a black nurse, upon the task of reducing infant mortality rates of 155 babies per 1,000 to closer to the 35 per 1,000 among white babies in the neighborhood. By 1919, Burritt was reporting to his patron that the “fabulous return of successful industrial stocks cannot compete with the return on this investment.” Of the 160 infants born the previous year,
only three infants died. A total of 208 of the 253 babies born in the previous eighteen months received physical examinations and nutrition support at a new milk station; and those that did not had moved from the neighborhood. The striking success of this work, Burritt concluded, led to the AICP decision to desegregate its convalescent home for sick mothers and babies in Westchester County. By the early 1920s Columbus Hill had increased its numbers to four black nurses: Thoms had personally trained two of these nurses and all had Henry Street postgraduate experience.27

Homer Folks joined Burritt in the interlocking circles of public health leadership. Folks, educated at Harvard and practicing as a social worker, had also served with the American Red Cross (ARC) in France both during and after the war. He returned to his position as secretary of the New York State’s Charities Aid Association, charged with creating cooperative bonds between private and public health agencies in all areas of the state except New York City. His wide-ranging interests included mental hygiene, infant mortality, and, as the presiding officer of the first White House Conference on the Care of Dependent Children in 1909, child welfare. But his abiding interest was in tuberculosis prevention and treatment. Folks was the first layperson elected president of the National Tuberculosis Association and viewed with excitement the fact that the Framingham Study’s data might undo decades of his own work encouraging New York State’s towns and counties to build tuberculosis hospitals.28 Visiting nurses in Baltimore, he told an AICP meeting in 1921, had presented compelling data at the Sixth International Congress on Tuberculosis in 1908 that TB in one member easily spreads to other members of a family. He returned from the Washington, DC, congress, he remembered, “weighed down by the burden upon us, apparently of starting tuberculosis hospitals.” Yet now, with the Framingham data—and a commitment to “medical knowledge and nursing supervision, and of actual aid and moral support”—one could keep families together and enable their ill loved one to fight their second war with TB: that of surviving, making a living, and keeping their households and affairs in order.29

Not surprisingly, Hermann Biggs, now commissioner of health for New York State, joined Burritt and Folks at important policy tables. Biggs, trained at Cornell University and Bellevue Hospital Medical School, had endured a bruising battle with the city’s private medical practitioners in the closing decades of the nineteenth century over mandatory TB reporting and monitoring. Biggs had won that battle but lost the war. Concerned citizens, nurses, social workers, as well as private physicians were required to report suspected as well as confirmed cases of tuberculosis to the city’s Health Department. Each day, the city’s public health nurses were to receive the names of new cases in their
respective districts, visit them in their homes, and assess and report on the home’s general cleanliness and sanitation. The nurse then taught families about proper sleeping arrangements, and the necessity of fresh air, good nutrition, cleanliness, nutritional access, the importance of not sharing eating and drinking utensils, and the proper disposal of expectorants. Ideally, the nurse would visit all patients without the means to pay private physicians monthly and, when necessary, she also had the power to begin a process for those poor families that could lead to the hospitalization in a sanitorium for an ill adult, or in a preventorium for an exposed child.

But, in reality, there were too few public health nurses, and those assigned to work with poor tubercular patients concentrated only on those deemed more difficult and recalcitrant. In addition, there were too many ways private physicians could evade reporting requirements for those with access to their care. And these physicians protested vehemently about how such requirements intruded on the confidentiality of the doctor-patient relationships. Biggs had learned to tread cautiously around the prerogatives of private medical practitioners even as what historians Amy Fairchild, Ronald Bayer, and James Colgrove call the “war time enthusiasm for controlling VD” led to congressionally backed monies for a new campaign for venereal disease detection and treatment in the 1920s.30

Livingston Farrand, the past chair of the ARC, had just returned to New York City from the University of Colorado to assume the presidency of Cornell University, as well as a seat on the board of directors advising Josephine Goldmark in her survey of US nursing education. But he was well known to leading public health reformers through his leadership positions in the National Association for the Study and Prevention of Tuberculosis and the American Public Health Association, serving as the editor of its American Journal of Public Health from 1912 to 1914. Farrand trained as a physician at Columbia’s College of Physicians and Surgeons but pursued academic interests in psychology and anthropology as well as tuberculosis. He, too, served in postwar France for the Rockefeller Foundation’s Commission for the Prevention of Tuberculosis in France. His associate director in France, James Alexander Miller, had been instrumental in establishing and then chairing the New York Tuberculosis Association when he returned. Miller had originally trained as a chemist, and eventually secured a position in the research laboratory of New York City’s Department of Health. His work caught Hermann Biggs’s attention. Biggs encouraged Miller to attend medical school at Columbia, promising to hold his position in the laboratory until graduation. Miller never returned to the laboratory; rather, he went into clinical practice and came to the planning of a new
health center as well as a new campaign for tuberculosis control as one of the leading clinicians in the field of pulmonary diseases and tuberculosis.\textsuperscript{31}

\textbf{Planning a Health Center in East Harlem}

The idea of health centers was not new to New York City. In the late nineteenth century, public health nurses, politicians, and philanthropists joined forces to create local infant welfare stations to promote clean milk and breastfeeding in the battle to decrease infant mortality.\textsuperscript{32} In 1914, S. S. Goldwater, the city’s health commissioner, opened a geographically defined health district in the Lower East Side to try to bring the work of the Health Department closer to the individuals in need. The success of this initiative led Goldwater’s successor, Haven Emerson, to extend the concept to the entire borough of Queens, carving it into four new health districts. But, as was so often the case with early twentieth-century public health departments, a change in political administration brought a change in both health commissioners and public policy. The new city government leaders in 1918, abetted by health department bureau chiefs who saw their centralized authority diminished by local district administrators, abolished these health districts.\textsuperscript{33} By the early 1920s, a once brilliant New York City Health Department had entered what its historian, John Duffy, describes as the “Years of Travail.”\textsuperscript{34} The \textit{American Journal of Public Health} warned of a “disorganization” that would destroy the department’s reputation, as political patronage rather than service delivery had become the function of the department.\textsuperscript{35} Demonstration projects, like those being planned for New York City, would serve as bracing antidotes to this malaise.

Homer Folks, also a member of the Board of the New York County chapter of the American Red Cross, took the lead in turning its support of health centers into a reality. The national offices of the ARC had pledged a building, and, in keeping with the practices of other ARC-sponsored health demonstration projects across the country, the local chapter surveyed the various neighborhoods in the city. It eventually chose East Harlem, a defined geographic district recognized by the city’s health department, as the site of the projects. It met criteria in that it was a defined local area of approximately 100,000 people with twenty-three private health and welfare agencies who agreed to cooperate by locating all their neighborhood offices in one centralized site. It did not meet criteria in that it hardly represented a cross-section of the city regarding health outcomes and standards of living.\textsuperscript{36} Yet, the ARC chapter realized, in the socially, ethnically, and racially stratified world of New York City neighborhoods, there seemed no such geographically defined area that could.
The officially defined boundaries of East Harlem stretched from East 99th Street to First Avenue, East 104th Street to Third Avenue, Third Avenue to the Harlem River, and finally, from the Harlem and East Rivers to East 129th Street. It was home to what the city recognized as the “largest Italian colony in the western hemisphere.” It grew as late nineteenth-century immigrants from Southern Italy sought relief from the traditional but overcrowded ethnic neighborhoods of the Lower East Side. Yet, their standards of living hardly improved. Most tenements were dilapidated “old law” buildings: they had been constructed before newer building codes took effect and they had shared outdoor bathrooms and no running water. A few men worked as skilled artisans but most were employed as laborers, factory hands, or petty tradesmen; and one-third of its women had to supplement their families’ incomes by homework making paper flowers or by sewing factory-consigned garments. With the postwar immigration restrictions of 1921 and 1924, their numbers were evenly split between those who were foreign-born and those born of foreign parents. And they and their babies died at rates greater than those for New York City as a whole. In the period between 1916 and 1920, adults in East Harlem suffered a 15.3 per 1,000 mortality rate as compared to 14.7 in the city; during the same time period, their babies died at rates of 100.6 per 1,000, rather than the 83.2 mortality rate for the city as a whole.

East Harlem was also home to one of the most distrusted immigrant groups in the United States. Its inhabitants hailed from the poor, agricultural Mezzogiorno, the southernmost part of Italy that was connected, in the public imagination, with notions of pervasive superstition, illiteracy, dishonesty, violence, and crime. These individuals’ darker complexions; deep suspicions of institutional authorities that had only oppressed them in their native land; emotionality; particular dialects and religious practices; devotion to the domus (or family) above nation; and ritualized, hierarchical patriarchal practices that left little room for self-expression raised profound anxieties about race, assimilation, norms of citizenship, and proper gendered relationships.

Folks and his colleagues dreamed of control: of finally having an opportunity to rationalize a “criss-crossy” and inefficient system of private philanthropy and public health that brought material resources and healthcare to the homes of the deserving, and frequently tubercular poor. But they knew that had to start incrementally. They had to first work on a system of care coordination: of bringing all the East Harlem neighborhood’s health and welfare agencies together in one building for “one-stop shopping.” In their minds, each agency would maintain its own budget and administrative structure. But they hoped to “demonstrate” that there would be increased service utilization and
Figure 1. Map of the East Harlem Health and the East Harlem Nursing and Health Demonstration Projects Neighborhoods

better health and welfare outcomes when services were more physically accessible to those in need.

But increasingly, the social reform leaders of almost all private organizations had nightmares about six or seven nurses and social workers descending on one unfortunate family—each interested in a part of a problem rather than one worker approaching the family as a whole.43 A poor family that included a father with tuberculosis, a child with pneumonia, and a new infant, for example, might be visited by a city health department nurse with experience in tuberculosis, a VNS nurse to provide the bedside nursing of the sick child, an MCA nurse to supervise the health of the new mother and baby, and an AICP social worker to help the family obtain good nutrition and material resources.

Thus, in addition to demonstrating the value of health and social welfare care coordination through a health center, New York City’s unique contribution to the national health center movement would be a subsidiary demonstration involving nurses that would be one of care control. All of the city agencies providing nursing services in the neighborhood of East Harlem—the Department of Health, Henry Street, MCA, AICP, and Saint Timothy’s League of lay women supporters of public health nurses—would pool their resources, personnel, and dollars into one controlling organization with its own governing board.44 The intent would be to prove that a unified nursing service could deliver more effective, more efficient, and more intensive care to more families than the prevailing fragmented one. But there was a problem. Both the physician S. Josephine Baker, then head of the city’s Bureau of Child Hygiene that employed the predominant number of nurses in the Department of Health, and Lillian Wald said no. They immediately dismissed the idea of anyone else supervising their nurses.

Folks knew that bringing the city’s own public health nurses into a centralized service would be a long process. Unlike nurses in other private agencies who had to rely on their powers of persuasion, the city’s nurses had official police authority to identify and report suspected cases of communicable diseases, to institute quarantines, inspect homes, and provide continued surveillance of those receiving treatment in the city’s clinics. Wald’s resistance was not unexpected but, unless managed well, threatened to derail their grand plans. The officials at the Rockefeller Foundation bluntly told them that the participation of Henry Street, which it also financially supported, was “key” to any Foundation support of the demonstration project. They also offered a strategy. “Confidentially,” Foundation officers suggested, it would be Annie Goodrich, now the current director of the VNS at Henry Street, rather than Wald, who they reported as retired, who needed to be “won over.”45
Wal had withdrawn from the day-to-day operations of Henry Street, but she had hardly retired. She immediately reengaged, expressing objections to two aspects of the nursing demonstration. She believed that the highly respected work of her Henry Street nurses would be compromised if outside nurses were to supervise their practices: that they would not be held to the same high standards that governed Henry Street’s bedside nursing care. More significantly, she objected to plans to use the nursing demonstration to research one of the most hotly debated questions in national public health nursing practice. Should the organization of practice be built on a “generalized” model where one nurse met all the nursing and health needs of a defined neighborhood, as it was at Henry Street? Or should it be organized around a “specialization” model where one nurse developed the knowledge, skills, and techniques in defined areas such as tuberculosis, maternal-child, and school nursing—as it was in the city’s own health department? Wal declared that question had already been definitively answered: Generalized nursing practice had definitively proven its worth. To investigate further wasted time and resources.\textsuperscript{46}

Folks called in reinforcements. He reached out to Burritt and John Gebhart, the AICP’s director of social welfare. Burritt sincerely believed in generalized nursing as “the future thing.”\textsuperscript{47} But he also knew of the significant debate that still existed in public health and public health nursing about how its practices should be organized. A case for specialization in public health nursing could still be strongly argued: It was simpler in its organization; its practitioners were more easily supervised; and it did not lose the important work of health education to the priority demands for nursing acutely ill patients at home. Specialized public health nurses, particularly in areas such as tuberculosis nursing, also had more expert knowledge and more skilled techniques that contained cross-infections.\textsuperscript{48} Moreover, he was stunned that Wal claimed “complete surprise” at the care control aspect of the proposed nursing demonstration. The Henry Street Board had approved the proposed demonstration, but Wal and Goodrich stated they believed that they had only pledged participation. Burritt and Gebhart had a lengthy conversation with Wal and Goodrich that involved both “Homerian diplomacy” and the bluff that if Wal would not agree to let Henry Street join the demonstration, “it would go forward without her cooperation and that she would, therefore, be left in the position of opposing an important future development in the nursing field.”\textsuperscript{49} Wal and Goodrich finally agreed to participation, but it came at a price. Maternity Center Association nurses had to withdraw their prenatal work from East Harlem homes, leaving all home visiting within the domain of Henry Street nurses in East Harlem.\textsuperscript{50} With a building donated by the American Red Cross and funding promised by
the Laura Spelman Rockefeller Memorial, a trust of the Rockefeller Foundation dedicated to supporting the health and welfare charities of the late wife of John D. Rockefeller Sr., the planned demonstrations could become realities.

**Planning a Health Demonstration in Bellevue-Yorkville**

Burritt again faced resistance from Lillian Wald when he approached her about Henry Street nurses’ participation in the Milbank Memorial Fund’s planned health demonstration in the Bellevue-Yorkville section of the city. Burritt has secured financing from the fund to resume a small home hospital in an available apartment building in 1919, and by 1921 he dreamed, along with John Kingsbury, his protégé and the new executive secretary of the fund, about plans “to home hospitalize entire sections of the city.”[^51] The Framingham Study was, in Kingsbury’s opinion, one of only “average” dimensions. What he was seeking in the home hospital concept of how to care for families when a member had tuberculosis was a “monumental enterprise” for the $2 million the Fund stood ready to invest in health, particularly public health, work.[^52] Public health nurses would yet again be critical to the success of this kind of demonstration. But now they would incorporate specialized tuberculosis nursing practices into their generalized work—they would bring into their practice one form of communicable disease care that had long lay outside it.[^53] This was a plan long advocated by leading public health nurses across the country. Elizabeth Fox, the national director of the American Red Cross’s nursing service and an invited participant at the 1922 Milbank Fund’s Advisory Council Annual Conference—a council of national experts that advised the fund about the direction of its planned demonstrations—supported this plan. “I saw in your program somewhere the necessity of adding tuberculosis nurses,” she reported, “and it immediately struck my eye as one of the things I hoped you were not going to do.”[^54] But the issue for Wald was, again, not practice but her own control. Five months after her initial discussions with Burritt, she finally agreed to let her Henry Street nurses participate in the Bellevue-Yorkville demonstration if they had their own Henry Street supervisor.[^55]

But in this instance, Wald was the least of Burritt and Kingsbury’s problems. At a March 1923 conference convened by Albert G. Milbank, the president of the Fund, to consider a plan for the control of tuberculosis in New York, Hermann Biggs, now commissioner of health for New York State, laid out all his objections to Burritt and Kingsbury’s proposed enterprise. If he had extra money, would he spend it on TB work? No he would not: TB deaths, along with those for typhoid fever, infant mortality, and diphtheria, had been steadily declining in the state, but deaths from cancer, kidney, and cardiac diseases

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had been as steadily increasing. “It is in the degenerative diseases of middle and advanced life,” he told his audience, “that the advances are to be made in the future.” A tuberculosis campaign had value, he explained, but only as a “text” that the wider constituents of the general public and private medical practitioners understood and supported. The real lesson of the Framingham Study, he concluded, involved the importance of a general medical exam for all men, women, and children that identified and treated presumptive and actual cases not only of tuberculosis but also of those new diseases responsible for increasing mortality rates. Biggs had been trying to promote the value of general medical exams in New York City and State for years, but with minimal results. Doctors of the “old day” would not accept this new practice; and their potential patients remained suspicious that this was but another initiative to line physicians’ pockets with extra money. In Bigg’s considerable and influential opinion, a demonstration that would influence patients to demand and private medical practitioners to provide general medical examinations would be of “inestimable value.” More concretely, he predicted, it would also add ten to fifteen years to the average American’s life expectancy. By 1924, any reference to tuberculosis had been dropped from plans for the demonstration project planned for the Bellevue-Yorkville section of New York City.

The Bellevue-Yorkville demonstration was itself nested within a series of three demonstration projects the Fund supported in New York. It had appointed a Technical Committee that included Biggs, Burritt, Folks, Farrand, Miller, and Haven Emerson, who also sat on the board of the East Harlem project. The committee’s charge was to operationalize the Fund’s commitment to “demonstrate” in three different—yet typical for their size—communities that the intensive use of “all known health measures” would substantively reduce rates of mortality and morbidity at a cost the community would willingly pay to ensure the continuation of the demonstration’s initiatives when Milbank funding ended. It was also charged with treading lightly around the concerns of private medical practitioners. As Edward Baldwin, a Massachusetts physician involved with the Framingham Study, recounted to the committee, private practitioners had no problem with tuberculosis demonstrations: these physicians rarely treated poor tubercular patients, who were instead sent to sanitariums. But any hints that a demonstration might attack rates of typhoid fever, scarlet fever, and other diseases would bring howls that an outsider “will take the bread out of my mouth.”

In 1922 the committee chose Cattaraugus County, in rural upstate New York, and Syracuse, a mid-sized city also upstate between Albany and Buffalo, as the sites of its first two demonstrations. The third, in a “metropolitan area,”
Figure 2. Map of the Bellevue-Yorkville Health Demonstration Project Neighborhoods

presented more problems. Brooklyn wanted to host the demonstration, but the prestige lay in a site in Manhattan. By 1924, the committee had decided on the Bellevue-Yorkville sections of the city. This was a two-square-mile area in the central east side of Manhattan between 14th and 64th Streets and from the East River to 4th Avenue for most of the district, but slipping up to 6th Avenue in its northern section to include established tuberculosis clinics in Yorkville as well as Bellevue. In some ways this was an odd choice: Census data about mortality and morbidity were deemed unreliable as the district’s populations had been sharply declining in the face of rapid commercialization. In addition, the district was flooded with workers during the day who returned home at night to other areas of the city or suburbs. But its strength was seen in the economic diversity of its population ranging from poor and working-class families in Bellevue to middle-class and even some upper-class families living in new apartments in Yorkville. Most importantly, however, the Bellevue-Yorkville district was rich in hospitals, including some of the most respected ones in the city, outpatient clinics, and private medical practitioners—the key constituents the demonstration wanted most to reach.60

Yet, it faced immediate resistance from an unconsidered constituency: the people it sought to serve. The Milbank Memorial Fund’s 1924 announcement that it would spend $2 million to improve the health of the citizens of New York was met with some skepticism in an article in the New York Times. Will they want to be helped, it wondered. Are they willing to “be lessoned in these things by strangers from the outside”? The implication of the announcement, it continued, “is that at present the habits of these people are bad or at the least unwise in matters of sanitation and hygiene, but it has not been reported that they have made any such admission or appealed for the reformers to come among them and improve their condition.” There was only one thing that merited this intrusion of privacy, it concluded. In the tenements, “most of the mothers have learned that a visiting nurse, though unmarried, may know about the care and feeding of babies a thing or two that was not known by mothers and grandmothers in ‘the old country.’ ”61