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CHAPTER 1

Midway between the Pharmacist and the Physician

The Work of the Henry Street Settlement Visiting Nurses, 1893–1944

1929

Ellis M. Black, MD
Chair of the Medical Economic Committee,
Westchester Medical Group, New York

My dear Dr. Black:

Your letter as Chairman of the Westchester Village Medical Group addressed to Miss Elizabeth Neary, Supervisor of our Westchester Office, has been referred to me for reply. May I call the attention of your group to the fact that in administering the work in that office, Miss Neary does so as a representative of the Henry Street Settlement Visiting Nurse Service and in accord with definite policies in effect throughout the entire city-wide service. It has been the unvarying policy of the organization over the 35 years of its service to work in close cooperation with the medical profession doing nursing and preventive health work entirely and avoiding any semblance of the “practice of medicine in competition with the doctors.” . . .

[We] will call a meeting . . . to which the members of your group will be invited for a frank discussion of our common problems.

Very truly yours,

Elizabeth Mackenzie,
Associate Director of Nurses
[Henry Street Settlement, New York]
In 1929, Elizabeth J. Mackenzie, associate director of nurses for the Henry Street Settlement (HSS), wrote this letter to the chair of the Medical Economic Committee of the Westchester Village Medical Group, clearly stating her disapproval of the medical group’s accusation that the Henry Street Visiting Nurses were practicing medicine—that is, diagnosing conditions and prescribing medicines. The Henry Street Settlement had been in existence since 1893, and its visiting nurses had been providing care on the Lower East Side of New York City for over thirty-five years. During that time the nurses had attended to a plethora of ills, including poverty, overcrowded and filthy living conditions, child labor, sweat shops, contaminated milk and water supplies, infectious disease, and high infant mortality. Since 1919, Henry Street nurses had also been working uptown in the Bronx, caring not only for the poor, but also for middle-class families who had fallen on hard times. During the 1920s, the Bronx medical society had occasionally questioned whether the nurses’ work was outside nursing’s scope of practice (as defined by the New York state nurse practice act); but by 1928, after several meetings with the Henry Street nurses, the medical society had been referring more indigent patients to them. Now, in 1929, with the collapse of the American economy, the Westchester Village Medical Group, a constituent of the Bronx medical society, was again protesting their work. The doctors particularly opposed the well-baby conferences that the nurses conducted. Their grounds were that the nurses were practicing medicine and “entering into economic competition with them.”  

Clearly irritated by the accusations, Elizabeth Mackenzie argued in her letter that the well-baby conferences (clinics) were solely for the purpose of health instruction for mothers with infants and preschool children, although she conceded that the nurses gave complete physical exams and immunizations. Defending the nurses’ work, Mackenzie pointed out that a “careful study of the financial standing of the patients attending these conferences” shows them unable to meet the regular charges by physicians for these types of services.” In other words, if the HSS nurses had not provided care in these clinics, the indigent children would have gone without well-baby checkups and immunizations.

Attending Patients in the Home

In order to understand the nurses’ role with regard to medications, it is important to understand the context in which these nurses worked. In addition to conducting the well-baby clinics, the HSS visiting nurses provided care for patients in their crowded tenement homes. In fact, much
of what the HSS nurses did was the administration of routine care commonly used by white, middle-class Americans when someone was ill. This care included bathing the patient, feeding him broths and other simple foods, changing the bed linens, and keeping the room well ventilated and clean. According to director Lillian Wald's records on the care of a patient with tuberculosis:

February 21: Mrs. K___ confined, attended by HSS nurses. Medicine, clothing, and bed-clothing given by HSS. Also eggs and milk. . . .

In this case, medications were used in conjunction with other treatments considered equally important.

The other part of the nurses' work was actually the provision of nursing care routinely given in hospitals in the early twentieth century. The administration of mustard baths and other treatments like mustard plasters, turpentine stupes, and enemas composed some of their efforts at symptomatic relief. For example, the nurses frequently gave baths [ordered by physicians as a treatment] to reduce fevers. Writing in 1902, HSS nurse Jane Hitchcock described the treatment:

A favorite method of reducing temperature with children is the mustard tub-bath. A child's tub is filled three-fourths full with tepid water. Mustard in the proportion of one heaping tablespoonful to a gallon is added. The patient is given stimulant before being placed in the tub; ice is kept on the head and constant gentle friction is applied during immersion. The effect of these baths is felt for several hours, and hence this method has been found most satisfactory in cases where the attendants cannot be depended upon to give regularly the hourly cooling sponge bath.

In addition to administering such treatments (prescribed or not), the HSS nurses also taught patients about various “positive health” steps they could take, like cleaning the house or boiling dishes contaminated with tuberculosis germs. However, more often than not these treatments remained invisible in the HSS records, as the nurses frequently summarized all of their activities in one word, noting that the patient was “attended.” To the nurses, such care was routine and hardly worth mentioning.

Although the Henry Street nurses’ care may have been routine, the conditions in which they practiced were not. Rats, mice, and roaches complicated the HSS nurses’ work. The vermin also deterred the nurses from taking the night shift. According to one nurse:
Peter had pneumonia, complicated with whooping cough. He is a beautiful yellow-haired boy, and even if the hospital could have admitted him, or his mother would have agreed to his removal (which she wouldn’t), I should not have liked to send him... The doctor had ordered bath treatments every two hours. These I gave until eight o’clock and the mother continued them... but when the temperature was highest she was worn out and active night-nursing seemed imperative... a service more difficult than it appears in the mere telling, for the vermin in these houses are horribly active at night.

Cultural Sensitivity

In all cases, the HSS nurses were challenged to understand cultural differences. In New York City in the early years of the twentieth century, the nurses—white and middle- to upper-class—came face to face with the health beliefs and cultures of the Irish, Italian, Polish, Russian, Hungarian, African Americans, and others. Typical of the HSS nurses, who were often shocked by what they saw, Lavinia Dock wrote:

... the fear of bathing and of air, so deeply grounded in European medical teaching, as it would appear, is universal among our foreign people, and it is a most piteous sight to come into a small, stuffy, crowded room, with every window tightly closed, and find a child blazing with scarlet [fever] or measles, with inflamed eyes, occluded nostrils, and angry throat, pasty and sticky with the dirt of a week upon him, and dressed in full woolen clothing, shoes and stockings, and an enormous scarf or towel swathed around his poor little neck, with probably a slice of greasy bacon tied underneath. The bed is invariably filthy, for the parents are afraid to annoy him.

Despite their shock, the nurses attempted to be as sensitive to the cultural and health beliefs of the immigrant families as their upbringing would allow. Moreover, the nurses were often assigned to work with the specific group with whom they could best relate. For example, according to 1901 HSS head nurse Jane Hitchcock: “Each nurses’ personal taste is considered and the one who finds herself most in sympathy with the Irish people is sent to an Irish district, the Jewish to a Jewish, the Bohemian to a Bohemian, etc.” While not willing to forgo teaching the immigrants American middle-class values, the HSS nurses were nonetheless willing to meet them halfway in order to establish a sense of trust. Hitchcock reserved judgment when she reported on one case:
The world in general has a mistaken idea that poverty is synonymous with dirt and squalor. While order and cleanliness, according to our standards, are hard to attain by the woman who must be wife, mother, cook, nurse-maid, and laundress all in one, they are often found to a remarkable degree. . . . This little kitchen into which the nurse entered shows thrift and cleanliness in its furnishings. There is disorder, true, but illness, a large family and the early hour give explanation. . . . The third door leads into the bedroom proper . . . the smallest of the three [rooms], with its one window opening into the airshaft. The bed fills just three-quarters of the room space . . . pushed into the corner, it is impossible to pass around it, and all work has to be done from the one exposed side. . . . With tactful suggestions from the nurse, the mother begins to see what help she can give. . . . After a couple of days a fairly orderly routine is established, windows are coaxed open, the mother or friends have learned many little procedures and often develop a surprising quickness at learning.11

Nonetheless, Hitchcock’s biases show through as she notes that she is surprised (probably because of their language barriers and poverty) by their level of intelligence.

The Origins of the Henry Street Settlement

Nurses’ *de facto* prescriptive care for the underprivileged on the Lower East Side began in 1893, when the settlement was first organized. In the last decades of the nineteenth century and well into the 1920s, immigration from Europe was at its peak. Thousands of Polish, Irish, Italian, Jewish, and Russian immigrants moved into the densely populated cities of the northeastern United States, trying to start a new life in America. Life in the congested cities was difficult for the poor. Racism, the rise of big business, and the distribution of wealth into the hands of a few spawned numerous social problems. Housing was expensive, and many immigrants crowded into tenements, typically with whole families and their rent-paying boarders sharing one tiny flat. Outside, the streets were littered with filth.

There was no plan for garbage collection, nor were there adequate drainage or sewage systems. As a result, the roads were a quagmire of mud and water, and uncollected garbage lined their edges. Conditions in the workplace were no better. Lower-class immigrant parents and their children, some as young as six or eight years old, worked long hours in poorly lit and unventilated factories and sweat shops. Many poor women did piecework in their homes in an attempt to make extra income. Sometimes
the women themselves were sick with tuberculosis when they handled the garments they were piecing; other times, the women piled fabrics on beds or tables in the same room as their infected children. Under these conditions, epidemics of infectious diseases were commonplace.

In 1893 Lillian Wald, a well-to-do, young graduate nurse from the elite New York Training School for Nurses, and her colleague Mary Brewster established the Henry Street Settlement House with the financial backing of philanthropist Jacob H. Schiff. Before that time, Wald had spent two years in a New York Training School for Nurses and supplemented that education with classes at a medical college. Wald described its origins in an article later published in the *American Journal of Nursing*:

About eight years ago tenement-house life in its most pitiable aspect was presented to me. I had been giving a course of lessons in home nursing to a group of proletariats from the older world—people who find a renewal of hope in New York. . . . One morning one of the women of the class was not present, and her little daughter came to ask me to call upon her mother, as she was ill. Despite my experience in a large metropolitan hospital, and the subsequent knowledge gained through a year's residence in a reformatory . . . , the exposure of that rear tenement in the lower East Side was a most terrible shock. . . . A picture was presented of human creatures, moral, and in so far as their opportunities allowed them, decent members of society, . . . up dirty steps into a sick-room where there was no window, the one opening leading into a small crowded room where husband, children and boarders were gathered together . . . impossible conditions . . . to me personally it was a call to live near such conditions; to use what power an individual may possess as a citizen to help them. . . . To a friend [Mary Brewster] the plan was revealed: “Let us two nurses move into that neighborhood; let us give our services as nurses.” Having formulated some necessary details of the plan, we proceeded to look for suitable quarters and in the search discovered the “settlement.” For the first two months of our experiment we two nurses lived at the College Settlement. After that the top floor of a tenement that gave reasonable comfort was our home for two years. . . . After that, Mr. Jacob H. Schiff [a wealthy banker and philanthropist], who from the very beginning had made us feel his support, encouragement, and confidence, suggested the change from the tenement quarters to a house, arguing that a more permanent basis would be established for these personal services if it were made possible for others to join us.”
After two years working from the tenement flat, Lillian Wald and Mary Brewster moved to a house at 265 Henry Street and set up headquarters for the settlement there. From its inception in 1893 until 1944, when the social and nursing activities were separated, the Henry Street Settlement (HSS) linked nursing, social welfare, and the public. In addition to providing social services such as kindergartens, study rooms, playgrounds, Boys’ and Girls’ Clubs, and summer camps, the Henry Street Settlement was unique in its operation of a visiting nurse service that provided skilled, professional nursing care to the thousands of immigrants who crowded into the ethnic ghettos of the city.

During the decades following 1900, the HSS nurses’ practice expanded as they cared for patients with a multitude of illnesses. According to Wald, the needs of these New York City residents were limitless:

There were nursing infants, many of them with the summer bowel complaint that sent infant mortality soaring during the hot months; there were children with measles, not quarantined; there were children with ophthalmia, a contagious eye disease; there were children scarred with vermin bites; there were adults with typhoid; there was a case of puerperal septicemia, lying on a vermin-infested bed without sheets or pillow cases; a family consisting of a pregnant mother, a crippled child and two others living on dry bread . . . ; a young girl dying of tuberculosis amid the very conditions that had produced the disease.

Initially Lillian Wald and Mary Brewster responded to these needs themselves, operating from their small flat on the Lower East Side and visiting families in their immediate neighborhood. They bathed patients, gave medicines (both home remedies and those ordered by physicians) and food, changed bed linens, and taught families to burn trash and sweep their apartments. Convinced that “the sickness they encountered in families was part of a larger set of social problems, Wald immediately began to mobilize an impressive . . . array of services . . . to provide patients with ice, sterilized milk, medicines [from their central medicine chest], meals, and referrals to many of the city’s hospitals, dispensaries, and, most important, jobs.” By 1895 Wald and Brewster had expanded their staff to include a powerful group of nurses, including Lavinia Dock, Adelaide Nutting, and Annie Goodrich, all of whom would go on to be leaders in the profession.

By 1900 the settlement employed twelve nurses “regularly engaged in systematic visiting nursing” and made 26,600 calls. Most of these calls were for acute cases, including pneumonia, typhoid, scarlet fever, and diphtheria—and nurses gave the care, administering both home remedies and prescription drugs.
By 1909, the nursing service was outgrowing 265 Henry Street. The service now had eleven houses throughout the city and the HSS nurses began to live in flats of their own in the neighborhoods where they worked, rather than in the main headquarters on Henry Street. Some lived in Harlem, the northwest section of the city that housed the majority of the African American community. Just eight years earlier, in 1901, the settlement had expanded its work to include African Americans. That year the HSS had hired Jessie Sleet, an African American nurse who had been trained at Providence Hospital in Chicago, to work in an experimental role caring for patients in the “Negro” district. The HSS later expanded its visiting nurse services to include the Stillman House Branch of the Henry Street Settlement for Colored People in a small store on West Sixty-First Street, part of the San Juan Hill area on the west side of Manhattan. Working within the confines of a racist society, four black nurses visited sick black patients, who, after years of racism, poverty, and oppression, often distrusted white health care professionals. In 1918 these nurses made 33,024 home visits, routinely administering medicines as part of their care.
Caring for the Middle Class

By 1909, the Henry Street visiting nurses also expanded their work to include middle-class patients. That year Lillian Wald approached the Metropolitan Life Insurance Company with a proposal that involved HSS nurses. Until this time, charitable donations from affluent friends, revenues from fund-raising events, endowments, and “the occasional paying patient,” had kept the Henry Street VNS in business. However, as increasing numbers of families requested help, Wald turned to the Metropolitan Life Insurance Company with her proposal: she and her nurses would visit working- and middle-class patients for a small fee of fifty cents per visit. According to Wald, if Metropolitan Life would pay this modest fee, the company could “reduce the number of death benefits it paid.” In the spring of 1909, “a firm handshake sealed a contract between Haley Fiske, vice-president of the Metropolitan Life Insurance Company (MLI) and Lillian Wald. . . . The contract stated that, for a period of three months, trained nurses from HSS would provide health teaching and home care to MLI policyholders within a section of New York City. In return, Metropolitan agreed to pay the nurses fifty cents for each visit.”

Implementing this payment system was another problem. Patients themselves could request to have a nurse come, but if a nurse rather than a doctor visited the patients, something had to be done to cover their work legally, since nurses were not allowed to diagnose and prescribe. The solution was relatively simple. Physicians wrote “standing orders” that guided the nurses’ work. Backed by these orders, the nurses could treat patients. They could also refer patients to physicians and vice versa.

Within four years, HSS nurses were seeing thousands of patients each month. Their care involved both patient assessment and treatment, including medications that the nurses carried with them in their black bags. Over the next decade, the service grew exponentially. In 1923 alone, the visiting nurses made 37,262 visits and ministered to 52,126 patients. They cared for patients with a wide variety of acute illnesses, including “pneumonia, typhoid fever, dysentery, thrush, colitis, scarlet fever, whooping cough, polio, influenza, diphtheria, measles, mumps, bronchitis, enteritis, tonsillitis, nephritis, burns, rheumatism, alcoholism, meningitis, tuberculosis, cardiac problems, and those with ulcers and eye diseases. In addition, the HSS nurses visited obstetrical cases, following both mother and baby over several weeks postpartum.” By 1924 the VNS employed 253 nurses, each averaging eight visits a day, and charging a fee of “$1.15 per visit for those who could afford it and a sliding scale or free service” for those who could not. By 1926 the VNS was making over
300,000 visits each year. Thus, for years the HSS visiting nurses had been trusted and their work welcomed. Now, in 1929, when the Westchester physicians saw the nurses’ work as a threat to their incomes, it was not.

Medicine in the Progressive Era

The situation between the medical group and the HSS nurses was more complicated than a simple economic issue, however. The twentieth century was a transitional period in American medicine. Throughout the country, university-educated physicians were trying to gain control of the practice of medicine and the educational requirements for practice. The trend had started in the late nineteenth century. Then, university-trained physicians, having accepted the germ theory of disease and Lister’s work with antisepsis, began the struggle to get the public to use medicines and treatments based on scientific fact and prescribed by licensed physicians rather than using “cure-alls” prescribed by uneducated, self-proclaimed “quack” physicians. Trained physicians were particularly concerned about the false advertising of patent medicines in an unrestricted market. Some of the patent drugs were simply useless, but others contained “highly addictive substances like opium, cocaine and . . . acetanilide.”
So the doctors were justified in their concern about the qualifications of those who prescribed medicines. Almost any man who had the money and time to complete a short apprenticeship with a physician could claim that he, too, was a physician. The medical profession was also justified in its concern about the widespread availability and misuse of the addictive drugs and their serious negative side effects. In some parts of the country, where there were few physicians, almost anyone could sell “cure-all” medicines in unlabeled bottles. The public was also concerned because there were reports of lower-class mothers drugging their infants in order to get them to sleep while the mothers worked. In order to protect the public, the medical establishment demanded that the contents of patent medicines be identified and listed on the label. The profession’s efforts culminated in legislative action. On June 30, 1906, President Theodore Roosevelt signed the Food and Drug Act into law, requiring true statements on medication labels and the disclosure of “alcohol, opium, cocaine, morphine, chloroform, marijuana, acetanilide, chloral hydrate or eucaine” as contents. However, the 1906 Food and Drug Act did not restrict pharmacists from dispensing these over-the-counter remedies, nor did it restrict the public (at least the classes who could afford to) from purchasing them and keeping them at home.

During this time period, the few drugs available to treat illnesses were widely accessible through corner drugstores, dispensed by pharmacists to those who could afford them. There was little difference between commonly available household remedies and medical prescriptions, both of which provided symptomatic relief. Medical therapies and nursing care were often identical, as well. Drugs such as cough medicines, analgesics (for pain), and antipyretics (for fever), used in conjunction with skilled nursing care, frequently composed standard medical treatment.

Working in the Middle

The HSS nurses used both physician-prescribed medications and middle-class household remedies as they attended lower-class patients and their families. In essence, they practiced somewhere in the middle, between pharmacists and physicians, between domestic care and professional care. For centuries, but particularly since the founding of the American Medical Association (AMA) in 1847, physicians had claimed the right to prescribe medicines as solely within their professional boundaries. Pharmacists were to prepare and dispense drugs, but not to counsel patients about them. After the establishment of professional nursing in 1872, student nurses and their hospital supervisors administered physician-prescribed drugs and therapies.
At night and on weekends, however, if there were no pharmacist available in the hospital, nursing supervisors would also dispense medications, pouring them from larger bottles to smaller ones or from a large bottle to an individual medicine cup. The boundaries of nursing fluctuated with changing needs: nurses’ scope of practice increased when the sun went down and on weekends, when other professionals were unavailable. Their scope of practice also expanded when they practiced outside the hospital among the poor.

So, from the 1840s through the 1930s, the roles of pharmacist, physician, and nurse were, as physician Albert T. Lytle put it in his 1905 address to the New York State Nurses Association, “hopelessly entangled.” The roles of these professionals became even more muddled when the HSS began to employ graduate nurses to provide skilled care in patients’ homes. According to Lytle, nurses occupied “in reference to materia medica, pharmacy and therapeutics, and the patient, a field midway between the pharmacist and the physicians.”

The public’s self-administration of drugs further complicated the situation, as many middle- and upper-class women kept on hand many of the same drugs that might be prescribed by physicians. Thus, practicing between domestic care and professional medical care, the nurses worked in “the middle place.” According to a 1903 American Journal of Nursing article, a home medicine closet would typically contain “Listerine, alcohol, glycerine, Pond’s extract, brandy, lime-water . . . boracic acid powder, flaxseed meal, whiskey, spirits of ammonia, camphor, castor oil, turpen-

Figure 1.3: Original prescription, 1893: “honey, glycerine and sodium bicarbonate.” KC, CNHI
tine, chloroform liniment, arnica, camphorated oil, mustard leaves . . .
ichthyol . . . bicarbonate of soda . . . tablets of quinine, Frazer’s migraine
for headache . . . cascara, soda mint, calomel, essence of peppermint,
Jamaica ginger, syrup of ipecac, paregoric . . . lavender salts, iodine, lau-
danum, carbolic acid, oil of clove and calomel,” the same remedies pre-
scribed by physicians, dispensed by pharmacists, carried by the nurses in
their bags, and discussed in medical and nursing textbooks.

Prescriptions for Care

Some of the patients and families visited by the HSS nurses could not self-
medicate. They either didn’t have the money to buy drugs, or they didn’t
have the knowledge and skill to take care of themselves when they were ill.
In those cases, the physician’s prescription might be to provide a nurse. In
fact, in the Henry Street Settlement district, physicians’ requests for nurs-
ing care usually came hastily written on a prescription blank brought by a
sympathizing neighbor.

Rx: Dear Miss Wald: Kindly send one of your nurses to attend baby
___, 204 ___Street, top, front, right; pneumonia. The family is poor and
unable to give proper care.

The implication was, of course, that had it been of middle- or upper-class
means, the family would have been able to afford the necessary remedies
and would have had the knowledge and skills to do so, or as Wald put it,
“ . . . if the mothers had sufficient leisure or sufficient intelligence.” For
those who did not, the HSS visiting nurses would provide access to that
“proper care.” Physicians trusted the nurses to do so. The nurses were
equipped not only with the necessary medicines, but also with the profes-
sional training needed to administer them. One nurse described that
“proper care”:

In amongst these pillows, covered by some and completely surround-
ed by others, is the patient, a child of two years. The temperature is
104.5 degrees, pulse 140, respirations 50. The fair curly hair is tan-
gled and matted, the face and hands sticky with syrupy medicine,
while the feet and legs are still soiled with the dirt of the street. The nurse now begins her work. First, the pillows and feather-
bed are removed; then the baby’s over-abundant clothing is laid aside.
Next the cleansing soap and water bath is given, one of the cots
in the front room put into correct position as to light and air . . . and
the little one laid there clean and refreshed. . . . All this is prelimi-
nary to the more definite nursing work, which includes showing the
mother how to give the alcohol sponge-bath, swab the mouth,
arrange the ice-caps for the head, warm bottles if necessary for the
feet, and give the medicines and nourishment. Simple bedside notes
are left for the doctor, showing the temperature, pulse and respira-
tion, the general condition of the child, with a record of the work
done by the nurse.43

Clearly, nursing care—bathing and feeding the baby, sponging him with
alcohol, recording observations—was just as important as the drugs avail-
able at this time. In this case, the prescribed medicine was most likely a
“pulmonary sedative” such as “codeine, hydrated chloral, bromides . . . bel-
ladonna or wild cherry,” discussed in the 1903 *Physicians’ Handy Book of
Materia Medica,* and described by HSS nurse leader Lavinia Lloyd Dock in
the 1921 edition of her *Materia Medica for Nurses.*44

In many instances, drugs were applied externally. For example, care of
a baby with measles included “general care, mustard baths, saline enema-
ta, camphorated oil applied to chest.”45 Prior to the advent of pills contain-
ing ephedrine [to relieve nasal congestion] and diphenhydramine [an anti-
histamine used to treat colds], physicians and nurses gave mustard baths
and applied camphorated oil and plasters to relieve pulmonary congestion.
Registered Nurse Nora Nagle discussed the use of mustard as a therapy,
writing:

Mustard, as a counter irritant, has long been used both by the medical
profession and the laity. Easily obtained and easily applied, it has been
used with good effect in the hospital and the home . . . in such condi-
tions as a beginning bronchitis, (1) to relieve the congestion . . . and
(2) to ward off an attack of asthma.46

Bridging the Gap in Access to Medical Care

Bridging the gap between rich and poor, the HSS visiting nurses applied
such measures even in cases where there was no physician available to
order the treatment.47

Lillian Wald, who founded public health nursing while directing the
Henry Street Settlement, believed that access to nursing care should not
depend on patients being connected with certain physicians or hospitals.
According to Wald, nurses should respond to calls from individual
patients and physicians unencumbered by red tape or formality. In fact, she went on to say that “a child capable of giving the address or with a slip of paper in his hand giving the address of a sick person, will procure the nurse.” A 1906 report on the HSS nurses’ work confirmed that Wald’s belief was policy at Henry Street. More than half the 5,334 patients the HSS nurses visited that year were referred by families and only 1,648 by physicians. Discussing the polio epidemic in a speech to the American Academy of Medicine in 1917, Wald again reflected on the referral process, noting, “Very sick children were referred to the Settlement for care by many sources; last summer, drivers would get down from their trucks to tell of a case of poliomyelitis.”

Because of this referral system, it was not uncommon for an HSS nurse to observe signs and symptoms, make a presumptive (though unwritten) diagnosis, and begin treatment on her own before referring the case to a physician. According to historian Karen Buhler-Wilkerson, a “nursing visit usually preceded a call to the doctor, with the nurse deciding if the patient needed medical assistance at a dispensary, ‘uptown specialist,’ or hospital care.”

Sometimes the HSS nurses responded to the immigrants’ needs by teaching them the skills middle- and upper-class mothers learned from
their own mothers or from popular magazines like *Godey's Lady's Book*. For example, in a 1916 advertisement for a course in home health nursing, the HSS nurses noted that on “Wednesday evening, December 14th at 8:00 PM,” the nurses would discuss “uses of moist and dry heat, and how to make and apply flaxseed poultices, fomentations, hot salt bags, hop bags, turpentine stupes etc.” They also advertised that “on Wednesday, January 4, at 8:00 PM” they would teach “How to apply iodine, liniments, plasters and lotions.” Nurses, physicians, and the lay public all used these remedies as therapeutic treatments to provide symptomatic relief. Besides being available in the ladies’ magazines, information about these therapies was included in both nursing textbooks of the era and the AMA publication on medical prescriptions.

The Nurse’s Bag and the Central Medicine Chest

To carry supplies to the tenement homes in their district, the HSS visiting nurses used their black bags, the “District Bags” lent to the HSS nurses for a deposit of two dollars. These were “fully equipped except for bandage scissors, small scissors, probe, forceps and hypodermic: which the nurses were requested to provide.” Besides such articles as these and bowls, towels, dressings, and thermometers, the bag also included:

One three-ounce bottle for alcohol; five one-ounce bottles containing respectively—Listerine, whiskey, glycerine, tincture of green soap, and carbolic acid, 95%; one wide-mouthed bottle with screw-top for bichloride tablets; one one-ounce wide-mouthed bottle with screw-top for boracic acid powder; small screw-top bottle for cascara tablets; one two-ounce porcelain jar containing boric acid unguent; two one-ounce porcelain jars with ichthyol unguent, 10%; and Thiersch powder; one . . . jar for special dressing containing iodoform, balsam Peru etc; half ounce porcelain jar for Vaseline. . . .

The district bag also contained “a small box of cocoa . . . a jar of beef extract, fresh eggs for eggnog and albumin lemonade . . . and ‘jellies for the convalescents.’” Most of these medicines were household remedies, like counterirritants and antiseptics. Listerine, for example, was a mouthwash antiseptic. Ichthyol was an ointment commonly used “to aid in the healing of wounds,” and iodoform, a gauze containing iodine, was used to pack can-
cer wounds. Thiersch powder was a “combination of salicylic and boric acids, usually added to one quart of water to form an antiseptic solution.”\textsuperscript{59} Balsam of Peru was a “vascular stimulant and nerve sedative, antiseptic and disinfectant, used externally as an application to stimulate granulating surfaces [wound healing].”\textsuperscript{60} Both bichloride tablets and boric acid were antiseptic solutions, used to stem the growth of microbes. Other solutions were disinfectants, like carbolic acid. Green soap was a strong lye soap used to bathe patients, particularly those with lice or scabies. Some household remedies contained alcohol—whiskey was commonly used as a stimulant and analgesic. Others were narcotics—paregoric, for example, was “camphorated tincture of opium,” a drug that was often used to relieve colic in infants and was, in fact, one of the problem drugs that physicians wanted to regulate. Still other drugs, like turpentine, chloroform, and mustard, were classified as “counterirritants,” or “rubefacients,” which turned the skin red. Caustics included silver nitrate, to be used as an eye medication. Ammonia and kerosene oil were considered vesicants and were used externally.\textsuperscript{61} All of these home remedies were widely available—including the narcotics.

In addition to these standard ointments, solutions, and powders (many of which could be found in the medicine cabinets of middle- and upper-class families), the HSS nurses could select other medications they needed. The bags contained: “1 large bottle, 4 small bottles, 1 blue bottle and 2 tall screw-top jars”—to be filled from the HSS medicine chest at the nurses’ discretion,” and “1 medicine dropper and 1 syringe.”\textsuperscript{62} Filling these bottles themselves prior to making rounds each day, the nurses were assured that they had what they needed.

The HSS nurses did not always work alone, but they always used the medicine closet for their supplies. When a nurses worked in collaboration with a physician instead of on her own, she would meet the doctor in the early morning . . . at the stated hour to report on the cases visited the previous afternoon and that morning; receive orders and instructions for them or the new cases that he desires her to see; replenish her bag from the loan chest and medicine chest and recommence her rounds.\textsuperscript{63}

Although the contents of the central medicine chest are not identified specifically in the HSS records, it is very likely that it contained many of the drugs listed in Dock’s \textit{Materia Medica}, which was in its seventh edition in 1921. These may have included nitroglycerine for heart patients, aspirin, castor oil, cascara (laxative), sulphur, magnesium oxide (milk of magnesia), and belladonna (atropine), a heart stimulant.\textsuperscript{64} By the 1930s,
the medicine chest probably contained many of the drugs kept in stock at Camp Tapawingo, one of the summer camps operated by the Henry Street Settlement.65 Among numerous others, these included: tincture of iodine for the “disinfection and treatment of wounds”66; zinc oxide ointment (used for diaper rash); rhubarb and soda, for “strengthening appetite and digestion”67; cascara (a “laxative and cathartic”)68; and elixir of terpin hydrate, a cough medicine made from oil of turpentine.

From this wide assortment of remedies, the visiting nurses could choose different drugs based on the patient needs they anticipated on any
given day. No doubt they were well supplied. Next to gauze dressings, car-
fare, and telephone, “drugs and supplies” were a significant expenditure of
the organization.69

Necessary Knowledge for Safe Care

In the early twentieth century, nurses were legally responsible for the safe
administration of prescribed drugs,70 and the Henry Street nurses knew a
great deal about drugs. From the inception of professional nursing educa-
tion in the late nineteenth century, nurses had been learning about materia medica and administering medications to their patients. In the late
1880s, for example, student nurses were taught about giving “opium, amyl
nitrate, tincture of iodine, and calomel, as well as Turpentine stupes.”71 In
addition, they were taught the uses and administration of laudanum and
digitalis, as well as the proper technique for administering injections. Nurses were also instructed that “whiskey, brandy, liquid ammonia, nitrate
of amyl, atropia, belladonna, caffeine, cocaine, mustard, sulphide of zinc,
Gallic acid, ergot and pilocarpine,” should be kept “on hand.”72 By the
time the Henry Street Settlement opened in the 1890s and these drugs
were used, the nurses were familiar with them.

In addition, the Henry Street Settlement nurses were required to have
post-RN training in public health nursing before they could work as visiting
nurses. They had already had introductory materia medica in their training
programs and now had further education about pharmacy in the public
health curriculum. They were also taught how to care for patients in their
homes and what to teach them so that the patients might take care of them-
seves. Even after they took the prerequisite public health nurses training, the
nurses took advantage of continuing educational opportunities. As Lillian
Wald noted in a 1921 speech at Columbia University, many of the nurses
already held degrees from leading colleges and universities . . . but were
“availing themselves of the courses open to them because of [the settlement’s]
affiliation with Columbia University.”73 Clearly, these were not average hos-
pital staff nurses. They were experienced, well-educated nurses who had suf-
ficient and necessary knowledge to provide safe care.

De Facto Diagnosing

The HSS visiting nurse was often the first professional to see a patient.
Consequently, she was the one who made an initial, though tentative, diag-
nosis. In fact, HSS nurses routinely diagnosed common health problems
like ear infections, diarrhea, and thrush as they made “sick rounds” throughout the tenement districts. In one case, an HSS nurse diagnosed and treated a child and then referred him to a physician for follow-up. Visiting a second child, she administered a commonly used home remedy for diarrhea. Then, visiting a third household, the nurse gave the mother another household treatment for her baby’s sore mouth.

In one room, I found a child with running ears which I syringed, showing the mother how to do it, and directed her to Dr. Koplik of Essex Street Dispensary for further treatment. . . . In another room, a child with summer complaint to whom I gave bismuth and tickets for a sea-side excursion. . . . On the next floor, the Castria baby had a sore mouth for which I gave the mother borax and honey and little cloths to keep it clean.

During their home visits, HSS nurses observed and interpreted various signs and symptoms and took the required action, despite the fact that by law they were not allowed to diagnose. A 1934 American Journal of Public Health article described their reality:

It is not the essential purpose of the [public health] nurse to make definite diagnoses, nor necessarily to treat patients of her own initiative. . . . Despite this principle, obviously it is impossible to avoid making some diagnoses. To recognize measles, pediculosis, caries, kyphosis, conjunctivitis and similar conditions is not only difficult to avoid, but it is immediately desirable, in order to institute promptly the necessary measures for the protection of the rest of the family and community.

In the absence of the physician, HSS nurses did what they needed to do. They had no choice. If they were to provide safe and effective care, they had to make de facto diagnoses on which to base that care.

Prescribing?

Technically, the HSS nurses did not prescribe drugs for their patients. That is, they did not write prescriptions for medications to be filled at a drugstore. The 1903 statute regulating the registration of nurses in New York was explicit:

Before beginning to practice nursing every registered nurse shall cause such certificate to be recorded in the county clerk’s office of the
According to tradition and the law, “the treatment and cure of disease” included prescribing medicines, and this was to be done by physicians.\textsuperscript{79} In a 1906 American Journal of Nursing article, Albert Lytle, MD, was unequivocal in his remarks to nurses about their role in relationship to medications, reinforcing the law: “the nurse only administers [drugs] and neither prescribes nor dispenses.”\textsuperscript{80} Regulation #14 of the HSS was equally clear, specifying that “a nurse must never prescribe for a patient.”\textsuperscript{81} And, technically, following these rules, the HSS nurses did not prescribe; they followed medical orders as was customary, giving medicines prescribed by physicians or dispensing medicines from their bags. According to one HSS record:

Child of two years—pneumonia—parent poor—dispensary physician making occasional calls and receiving daily reports from nurses. Nurse visited daily for 3 weeks, two visits a day during the critical period, giving baths . . . cleansing mouth . . . instructing family . . . [giving] drugs from dispensary.\textsuperscript{82}

In this instance, the nurse was working cooperatively with the dispensary physician, reporting to him and giving the drugs he had prescribed. No doubt, the family had no money to fill the prescription, and the nurses, following Wald’s instructions to “take the prescription and have it filled, and relieve the immediate pressure,” purchased the drugs herself and administered them to the patient.\textsuperscript{83}

It was not only the medical profession’s ownership of the prescriptive privilege that limited nurses’ legal autonomy in practice.\textsuperscript{84} By the early twentieth century, the medical profession was increasingly assertive about its scope of practice as regulated by state laws. Both the American Medical Association and the American College of Surgeons (established in 1913) were gaining control of the profession and its practice. Furthermore, the nursing profession was not questioning their authority. In fact, quite the opposite was true. Nurse leaders were adamant that prescriptive authority was the purview of the medical profession. The preface to a set of “standing orders” for Chicago visiting nurses in 1913, which were to be “carried in the nurses’ bags” and “sent to every physician carrying free cases,” emphasized this regulation. According to that document, “No medication, not even castor oil, is included in this list [of standing orders] for obvious reasons.”\textsuperscript{85} Clearly, the nursing profession itself was identifying its practice boundaries, despite the practical realities.
By 1926, practice boundaries were becoming increasingly well defined. That year, in a draft of the Code of Ethics for the American Nurses Association, the nurse authors were unequivocal that the role of the nurse was complementary to that of the physician. The nurse was not to use her independent judgment to prescribe:

The term “medicine” should be understood to refer to scientific medicine and the desirable relationship between the two should be one of mutual respect. The key to the situation lies in the mutuality of aim of medicine and nursing: the aims, to cure and prevent disease and promote positive health are identical, the technics [sic] are different and neither can secure complete results without the other. The nurse should respect the physician as the person legally and professionally responsible for the medical and surgical treatment of the patient. She should endeavor to give much intelligent and skilled nursing service that she be looked upon as a co-worker and not a handmaiden. Under no circumstances, except in an emergency, is the nurse justified in instituting therapeutic treatment.86

The question remained—did the care of all urban poor qualify as an emergency?

Fluid Boundary Lines

The imaginary line separating nursing from medicine was fluid, especially when over-the-counter medicines were used. As has been noted, the HSS nurses recommended and used home remedies, which at the turn of the twentieth century were part of both professional nursing care and medical therapeutics. For example, borax glycerine (one part borax to four parts glycerine) “gently painted on four times a day” was a commonly prescribed treatment for thrush (a yeast infection commonly occurring in infants’ mouths).87 Nurses shared knowledge of this treatment with physicians. According to Shaw’s 1902 Textbook of Nursing, treatment for thrush was “a wash of borax water.”88 Since borax and glycerine were kept in home medicine cabinets at the time, it is likely that this treatment was also widely used by the lay public; whether the HSS nurse was prescribing a medical therapy, a professional nursing treatment, or a middle- and upper-class home remedy is not clear. Nor did it seem to matter much, as long as the infant received care.

In addition to borax and glycerine, both nurses and physicians used physiologic saline, particularly as a throat irrigation in the treatment of diphtheria or scarlet fever. According to a 1926 textbook of medicine:
When, in an infant . . . the throat becomes foul and in obvious need of cleansing as may occur in diphtheria or scarlet fever, there is nothing that meets the requirements as well as copious irrigation of the throat with hot physiologic sodium chloride solution. The infant, its arms confined by safety pinned blanket, is laid face down on the nurse’s lap, and the fluid is squirted from the nozzle of a fountain syringe backward into the little one’s throat in intervals between inspirations. The fluid escapes from the mouth and nose, carrying with it, at times, surprising quantities of mucus, pus, and necrotic material. The irrigation is continued until nothing further comes away. It is best not to add any medicament to the water as much of it is liable to be swallowed.89

Once again, the professional boundaries were fluid. In this case, the physician prescribed a nursing treatment using physiologic saline; in practice, nurses mixed physiologic saline according to recipes in nursing textbooks. Nurses were familiar with this standard treatment from their training school lectures and no doubt initiated it on their own accord when the need arose.

Cards of Instruction in School Nursing

In addition to administering prescription drugs and initiating treatments on their own when circumstances demanded it, the HSS nurses gave drugs and administered therapeutic treatments according to standing orders. Evidence of this practice is nowhere more apparent than in HSS school nursing activities, where the nurses used “cards of instruction”—standing orders to be implemented in the care of children with specific diagnoses.

Although physicians from the Department of Health had been inspecting American schools since the mid-nineteenth century, most of their attention had focused on the identification and exclusion of children with contagious diseases. In 1903 under an experimental program in New York City, nurses visited schools to treat children and follow up cases, with the goal of reducing absenteeism; only “the children suffering from serious disorders too advanced to be cared for in the dressing-room were sent home.”90

Henry Street Settlement school nurses visited, on average, four schools in a day, treating children who had “been selected by the doctor on his daily rounds.”91 In her “Daily Report,” HSS nurse Lina L. Rogers noted that she treated 893 cases in October (c. 1920s) in parochial schools #147, #12, and #31, and that these cases included “eye troubles, eczema, ringworm and minor wounds.”92 Each disease had its own treatment protocol outlined by the New York City Department of Health, which was to be
“followed without variation unless the Medical Inspector prescribes some special treatment.” According to those directions:

The following methods will hereafter be used in treating children sent to the nurse by the Medical Inspector of schools:

**Pediculosis**—Saturate head and hair with equal parts kerosene and sweet oil; next day wash with solution of potassium carbonate. . . . To remove nits, use hot vinegar.

**Favus (Ringworm of scalp)**—Mild cases: Scrub with tincture green soap; epilate; cover with flexible collodion. Severe cases: Scrub with tincture green soap; epilate; paint with tincture iodine and cover with flexible collodion.

**Ringworm of face and body**—Wash with tincture green soap and cover with flexible collodion.

**Scabies**—Scrub with tincture green soap; apply sulphur ointment.

**Impetigo**—Remove crust with tincture green soap; apply white precipitate ointment (ammonia hydrarg).  

**Molluscum contagiosum**—Express contents; apply tincture iodine on cotton toothpick probe.

**Conjunctivitis**—Irrigate with solution of boric acid.93

In compliance with such standing orders, the HSS nurses provided medical treatments to the children, noting that the work was done “with the equipment of the Settlement Bag, and in some of the schools, no more than the ledge of a window and the corner of a room for the nurses’ office.”94 Having treated the children, the nurse would take her list of names and “make visits in the homes after school hours,” interviewing the mothers and “giving whatever advice” was needed.95 According to school nurse Lina Rogers, the most commonly occurring conditions included contagious eye disease, pediculosis, eczema, and scabies, and school nurses had permission to treat these. They could not “at any time” treat trachoma (a serious eye infection), however, which was considered too high a “source of contagion.”96

**Interdisciplinary Conflicts**

While most physicians supported the HSS nursing activities in health promotion and the prevention of disease, not all were enamored of the visiting nurses’ work, particularly in relationship to dispensing medications
and treatments. In 1904 some members of the New York medical community expressed their concern that HSS nurses were in fact carrying drugs in their bags and making home visits to patients without physician referral. Word of their concern reached director Lillian Wald via a circuitous route, spreading from the downtown doctors to the uptown medical specialists and back to Wald in a letter from her friend Lavinia L. Dock, who was traveling in Europe. Writing to Wald from Paris on June 30, 1904, Dock reported the gossip she had heard about the Henry Street nurses:

Miss Maude Banfield [a nurse colleague] has just come to visit us and she told me an incident that I must tell you at once, though you may probably have heard it all. . . . She crossed [the Atlantic] on a steamer with Mrs. Felix Adler [a New York socialite] and to my amazement, she [Adler] seems to be quite violently in opposition to you and your work in this question of the nursing [and] the doctors. When she found that Miss Banfield was a nurse she immediately entered with much energy and determination, on what she called this “question” in New York and told Miss Banfield with strong disapproval that “Miss Wald’s nurses carried ointments in their bags and that they even gave pills! She is of the opinion that it is quite wrong for district nursing to be done in any way except under the strict control of the physicians—the nurses ought not to go to cases except on their orders—doctors ought to be in charge of district nursing associations—no nursing ought to be done in any other method. . . . It seems Mrs. Adler gets all these ideas from her brother-in-law who is a doctor . . . you must be on your guard against them. I don’t doubt that the downtown physician’s society has taken their complaints to the uptown men hoping to get there a stronger support and perhaps injure you in your finances. LLD97

Dock had long been aware that not all physicians were pleased with the independent aspects of the HSS visiting nurses’ work, particularly the administration of medications and treatments in the First Aid Rooms that the HSS nurses established. In the first aid rooms, established within their various settlement houses, the HSS nurses treated patients for all sorts of minor conditions. They changed dressings and administered topical ointments and remedies for “innumerable burns, local infections, cuts, bumps . . . small accidents . . . eczemas of the scalp and face, conjunctivitis, and troubles common in ill-nourished children.”98 The rumors reported by Maude Banfield were true: the Henry Street nurses did carry ointments in their bags, did in fact give pills, and did make home visits without physician referral. They also treated thousands of patients in the first aid dispensaries.
What is interesting is that Dock does not deny these aspects of the nurses’ role in her letter to Wald. She does, however, worry that the additional first aid rooms they had recently opened might also be criticized and suggests that the settlement should be sure to have standing medical orders for the care they gave, writing:

Of course we don’t practice medicine nor want to. . . . But they [the physicians] might say that our First Aid Room was a practice of medicine. . . . I think we’ll have to be more careful than ever to have always some doctor’s orders behind us.99

Clearly, the Henry Street nurses were stretching the limits of nursing practice, and Dock was concerned about the legality of their care. Having standing orders written by physicians would cover the nurses in that respect. Then the nurses could continue to provide care—that they were in fact qualified to give—to those to whom it would otherwise be denied.

Collaboration and Cooperation

Despite the conflict noted by Dock, during the late-nineteenth and early-twentieth centuries, many of the New York physicians and the HSS nurses worked out solutions to their boundary problems. From the inception of the Settlement, numerous physicians supported the visiting nurse service. For example, physician Dr. Paul S. Kaplan, an East Side Russian doctor, cared for hundreds of Russian immigrants,100 while imminent uptown specialists like Henry Koplik, Abraham Jacobi, Henry D. Chapman, Harry Lorner, Lollis Greenwald, and Marcus Rothschild101 also treated the poor, accepting referrals from the Henry Street nurses.

Others supported the HSS nurses for another reason: if the nurses made home visits to the poor or saw them in the first aid rooms, the physicians could spend their time on paying patients. Early on, with the endorsement of the local medical society, the Henry Street Settlement nurses established standing orders for emergency medications and treatments to ensure the legal operation of the first aid rooms.102 Standing orders were also implemented for school nursing. In fact, the standing orders provided a practical and convenient way for nurses to use their skills of physical assessment, planning, and implementation of care for the indigent, without bothering physicians.

In addition to working with the local medical society, the Henry Street Visiting Nurse Service established a medical advisory committee who “counseled on matters dealing with the relationship between the medical
and the nursing groups and the development of policies relating to the welfare of patients.”¹⁰³ That committee would be needed as a mediator between the nurses and the Westchester Village Medical group in 1929, when Elizabeth J. Mackenzie reported that “difficulties with a certain group of doctors in the Bronx,” while “not new,” had surfaced again.¹⁰⁴ The accusations were not surprising. Clearly the Westchester physicians were worried that the nurses would threaten their incomes. It was 1929, and the economic crisis that engulfed the entire nation began to focus everyone’s attention on money. A few years later, in California, physician anesthesiologists also challenged the limits of nursing practice. In their case, it was nurse-anesthetists who were the focus of attention.