Public Health Nursing: In Sickness or in Health?

KAREN BUHLER-WILKERSON, RN, PhD

Abstract: Public health nursing began in the United States as a small undertaking in which a few wealthy women hired one or two nurses to visit the sick poor in their homes. By 1910, the work of these nurses had expanded to include a variety of preventive programs. While most preventive programs originated with voluntary organizations, such as the visiting nurse societies, they were eventually taken over either by boards of education or health departments. As a consequence of the new division that resulted, sick nursing would increasingly become the sole domain of the voluntary organizations, while the teaching of prevention would become the responsibility of public agencies. By examining the history of public health nursing between 1900-30, this article considers why a movement that might have been significant in delivering comprehensive health care to the American public failed to reach its potential. (Am J Public Health 1985; 75:1155-1161.)

Introduction

By the last decade of the nineteenth century, American cities were experiencing a major transformation. Those first affected were the northern coastal cities where the concentration of immigrants and industry linked poverty to disease and dirt. Population growth alone required major adjustments in the lives of most city dwellers. With immigration accounting for much of this urban growth, ethnic, cultural, religion, and economic differences accentuated the separation between old and new inhabitants.

For many, the advent of the germ theory of disease simply heightened these concerns. Realizing, that individual health depended to some extent on the health of the population generally, the hazards of infectious diseases become an increasingly tangible concern. The knowledge that the diseases of workers—who sewed clothes in their filthy tenement homes or who processed food—could spread to decent, clean, and respectable citizens served as powerful incentive for renewed efforts to eliminate the menace of illness among the poor.

Like most city dwellers, the urban poor usually chose to stay at home during illnesses, relying on traditional healing methods or, perhaps, the services of a dispensary physician. Compared to the middle and upper classes whose diseases were supervised by frequent visits from the family physician either in their homes or, to a lesser extent, in the well-ordered surroundings of a hospital's pay ward or private rooms, treatment of the sick poor during illness seemed careless at best.

A few lady philanthropists, in New York, Boston, Philadelphia and Buffalo, found these grim realities intolerable. Motivated by their shared "vision" of the good society, they hired trained nurses to bring care, cleanliness, and character to the homes of the sick poor. As was the case with so many philanthropic activities, these nurses were expected to bring a message with their medicine. Disciplined and well-bred women, they were to raise the "household existence" with their "delicate instruction and firm convictions," and to protect the public from the spread of disease with forceful, yet tactful lessons in physical and moral hygiene. The image of the visiting nurse climbing the tenement stairs to save the indigent from illness and bad habits struck the fancy of a wide variety of social reformers.

As knowledge of these visiting nurses' work spread, the number of agencies organized to provide their services rapidly increased. These early visiting nurse associations, as they were called, began as small undertakings in which a few wealthy "lady managers" financed and supervised the work of one or two nurses. In most associations the nurses worked six days a week, eight to ten hours a day, and were able to visit daily eight to twelve patients. The ailments they encountered were commonly infectious, often acute, and always complicated by the families' social and economic circumstances.

Usually, after only a brief interval of tension, even the dispensary and private physicians, who cared for the sick poor in their homes, came to appreciate the work of visiting nurses. In the context of a widespread debate on "charity abuse" of health care facilities, the rapid acceptance of the visiting nurse may have been based on the rising cost of hospital care and the effort to reduce the number of charity patients seeking hospitalization. In their search for paying patients, hospitals valued any program that helped them shed their image as a "once charitable enterprise." Obviously, one way to relieve hospital burdens—caused by what some contemporary spokesmen asserted was excessive and indiscriminate charity—was to provide the poor with more care in their homes, while simultaneously teaching them how to stay healthy. From the perspective of the sick poor, the visiting nurse brought much needed care and relief from the often extreme burdens of illness. Thus, as the result of a complex set of social, medical, and economic needs, the visiting nurse, seemingly assured of success, entered the
twentieth century with a clear sense of purpose, backed by a
supportive constituency anxious to promote what appeared
to be an unambiguously valuable undertaking.

The New Public Health Campaign

It was the changing emphasis of the "public health
campaign" that would, within the first decade of the 20th
century, create a bond between these visiting nurses and
public health. By 1910, death rates, especially for infectious
disease, were declining and public officials showed no hesi-
tation in claiming their share of the success. Many others
agreed, that it was through public hygiene that these diseases
had been successfully combated: care of the water, food,
and milk supply; removal of garbage, ashes, and dirt; the
cleaning of streets; disposal of sewage; better housing; and
the control of contagious disease. But freedom from disease
no longer depended simply on community effort or the
construction of more public works. Winning the fight against
disease now required moving from public hygiene to per-
sonal hygiene. This new campaign would focus on the affairs
of the household and conduct of the individual's life. There
was nothing to be gained by uplifting the masses, it was
argued, unless each individual in the mass was to lift him/ or
herself.9-13

If public health was indeed an increasingly private
matter, then the task ahead required translating the knowl-
dge of scientific medicine into terms of personal effort and
responsibility. Education, declared C.-E.A. Winslow, a
leading proponent of this view, was a keynote of the modern
campaign for public health. The "new idea" of this cam-
paign was to bring "hygienic knowledge right to the individ-
ual in his home," where the information taught could be
adapted to the particular circumstances of each individual
and presented in the words of the kitchen or the sitting
room.14

In actuality, this idea of a "health visitor" originated
with Florence Nightingale and was first discussed in this
country in 1893 at the International Congress of Charities,
Correction and Philanthropy.15 In her widely read paper,
"Sick Nursing and Health Nursing," she outlined the details
of this new scheme which she had helped initiate in England
in 1892. In the Nightingale plan, these health missionaries
were to be ladies with special training and practical instruc-
tion.16,17

The only significant variation in the American version of
the Nightingale plan was to make the teacher of positive
health the visiting nurse, not a lady health missionary.
Already well established in the homes of the poor, the
visiting nurse was the logical choice, as one medical author-
ity suggested, to serve as "the relay station, to carry the
power from the control stations of science, the hospital, and
Having improvised a sick bed, the nurse encourages the child to eat, 1907.
(Photo credit: Philadelphia Visiting Nurse Society)

The busy nurse, giving care to a newborn, had little time to remove her hat. With sleeves rolled up, she demonstrated proper care to the older sisters of the infant. (Photo credit: Philadelphia Visiting Nurse Society)

the university to the individual homes of the community.”18 She was “preeminently fitted” for this function, explained C.-E.A. Winslow, because she was a woman and therefore possessed the patience and tact necessary to bring hygiene into the life of the tenements. Unlike the social worker, she knew the human body and what he described as its reaction to external conditions and to the hygienic conduct of life. Her approach was far superior to that of the physician because she was trained to see the body as a whole, while the physician’s vision was distorted by a preoccupation with special pathological conditions.19

Most nurses shared this viewpoint, and some even went so far as to suggest that this new field of health nursing differed so greatly from sick nursing that it might one day constitute a distinct profession. Why not, queried one editorial in the Public Health Nurse, “come boldly forth, one and all, and claim the right to exercise the promotion of health as a profession?”20

Asserting their independence, these nurses declared an end to “the old teaching” of the nurse as the handmaiden of the physician. She was instead an associate or co-worker of the physician who helped him produce results he could never accomplish alone. While some physicians still expected to find the nurse waiting “at his elbow,” more progressive physicians could be counted on, stated nursing leader Mary Gardner, to gladly give these nurses “a helping hand” by strengthening their new position with the patient.21-24

Health nursing seemed particularly well suited for those nurses seeking the opportunity for autonomous practice. Although these nurses still carried out the doctors’ orders, their new working conditions made it possible to discriminate as to doctors, cooperating with those working for “a higher standard of public welfare” while standing in but “remote and casual relation with those who have no such aims or desire.”25 These nurses appeared to be crossing the invisible and ill-defined line between medicine and nursing, as they believed it their business to select those cases requiring diagnosis, sending them where this might best be accomplished.

In the case of the tuberculosis patient, for example, the nurse was, according to Ellen LaMotte, an early leader in the field, “singularly independent.” There were no special orders; the doctor knew what should be done and the nurse knew what to do. Further words were, she claimed, unnecessary. Patients could go for months without seeing the doctor or even change physicians, and it would have no significant impact on their daily regimen. It was the nurse who was in charge of the patient’s care, who was there through the long months of illness, and who moved the patient from doctor to doctor. Some exploitative or ignorant physicians reacted to such behavior on the part of nurses with antagonism and opposition, but, according to LaMotte, they were simply “holdovers from a passing regime.” In such cases the nurse simply proceeded with her duty even if at seemingly cross purposes with the physician.23 As those nurses entering this new field suggested, what they intended to do was certainly not, in the words of nursing leader Adelaide Nutting, “nursing in the ordinary sense of that term.”25

Prevention Programs, Services

Visiting nursing willingly added these new preventive tasks to their traditional responsibilities of caring for the sick at home. By 1910, the majority of the large urban visiting nurse associations had initiated preventive programs for school children, infants, mothers, and patients with tuberculosis. While pleased by this sudden growth of their new enterprises, the ladies who managed these associations found themselves overwhelmed by the need for correspondingly rapid increases in their sources of support. As a result, not only was the focus of these programs a radical departure, but the methods used by the lady managers to finance them were equally unprecedented. Unable to finance any large new programs, the ladies used two methods to entice others to pay for these new works—the joint venture and the
required the first voluntary societies and, not surprisingly, visiting nurse associations were among these lady managers' perspective, the responsibility of the growing number of voluntary societies for the prevention of tuberculosis and, ultimately, the city government.

Thus, the role of visiting nurse associations in the development of the campaign against tuberculosis was most frequently that of partners in a joint venture. Typical of this approach was the work initiated by John and Isabel Lowman in Cleveland. John Lowman was a member of the Western Reserve Medical School faculty, and Isabel Lowman an active member of the Board of the Cleveland Visiting Nurse Association. Concerned about the lack of services for tuberculosis patients, the Lowmans went to Germany and France in 1903 to study treatment of consumption. Following their trip, John Lowman began to open tuberculosis dispensaries—four by 1905—while Isabel Lowman and her committee on tuberculosis began to raise money to provide Visiting Nurse Association staff to visit the dispensary's patients. With the help of the Lowmans, the Cleveland Anti-tuberculosis League was organized in 1905, and by 1908 was able to assume all expenses for these tuberculosis nurses. In September 1910, the League's report to the mayor on tuberculosis conditions in the city resulted in the creation of a Bureau of Tuberculosis within the Department of Health. By 1913, all tuberculosis nursing was being financed by the city, which saw itself, as one health officer suggested, as having "come to the rescue and provided funds for the support of the work."

For the visiting nurse, these circumstances created a time of unlimited possibilities. Visiting nurses could be found working for department stores, factories, insurance companies, boards of health and education, hospitals, settlement houses, milk and baby clinics, playgrounds, and hotels, as well as for visiting nurse associations. Not surprisingly, the number of agencies seeking their services had increased from only 58 in 1901 to nearly 2,000 by 1914.

**Voluntary vs Official Health Agencies**

The outcome of this rapid growth in preventive services varied from city to city with voluntary and "official" government agencies assuming essentially unpredictable, often overlapping, responsibilities. As the confusion grew so did the debate as to the relative functions of the voluntary or "nonofficial" versus the official health agencies. The central concern was one of control. As Haven Emerson, a former Health Commissioner of New York City, later remembered, "competition and rivalry in methods, resources and accomplishments became as keen as in selling soup or advertising tooth paste."

While locally voluntary and public agencies negotiated their rather idiosyncratic relationships, publicly the struggle for consensus continued in the journals. The views of the public health nursing leadership and their predominately voluntary organizations most commonly appeared in the
Public Health Nurse, while those of the public health physicians and their official agencies were usually expressed in the American Journal of Public Health.

In these articles, voluntary organizations characterized themselves as fulfilling a set of responsibilities that they could accomplish with "peculiar fitness and effectiveness." They saw their purpose as assisting or supplementing official activities through education, research, demonstration, and standardization. Health officials, they claimed, could not attend to the details of their administrative work and simultaneously conduct the needed investigations. Nor could the health department be justified in using tax money to test new methods of work. It was therefore the task of the voluntary agency to conduct these experimental programs. Once the work of a particular program was established, public interest aroused, and the most effective methods established, the official agency could, they argued, easily obtain expansion funds for their continuation as part of a governmental program.36,37

Thus voluntary agencies saw themselves as a cornerstone of public health work. As Isabel Lowman described it, they were "an experimental laboratory whose cost in energy and money must ever be a surtax on the good will of the private individual."36 While admitting that at some point all health activities might conceivably be taken over by public health departments, the voluntary agencies claimed that the time had not yet come. Organizations for community health were far from complete and health officers were far from wise, contended these voluntary agencies, while the public was not educated to the point of recognizing the need to provide sufficient money for health programs.37

In contrast, some health officers tended not to see the activities of voluntary health organizations as supportive or cooperative, but as competitive and self-serving. The growing popularity of public health, declared Francis Curtis, Chairman of the Newton, Massachusetts Board of Health, causes clever people to see it as a means for justifying the existence of their non-official agencies.38,39 According to such public health officials, private health organizations had "mistaken their functions and misunderstood their relationship to government." Such organizations needed to be put in their proper place: "standing back of and helping the official agencies, placing themselves at the disposal of the health officer and permitting him to direct their activities according to his plan."38,39

As might be expected, debate over the proper domain of public health practice was not confined to these struggles between voluntary and public organizations. Attempts by health departments to extend the focus of their concerns also often resulted in conflict with the medical profession. Inevitably, most health officers found themselves forced to abandon claims to any curative activities that might be construed as threatening the economic well-being of private physicians. Consequently, despite much ongoing discussion, health department and school health services become increasingly preventive.40-42

What they chose for themselves, they not surprisingly chose for their employees and, accordingly, many health officers believed the work of the public health nurse was hygienic, not therapeutic. Thus, an inescapable, though seemingly unexpected, consequence was the limitation of the activities of these publicly supported nurses to the prevention of disease, leaving the care of the sick to the visiting nurse associations. Some health officers even went so far as to suggest that nurses who spent any significant amount of their time providing bedside care should not even be classified as public health nurses.43,44

The nursing leadership, many of them superintendents of visiting nurse associations, were outraged by such assertions. Visiting nurses, they insisted, had always been teachers of prevention and hygiene and had in fact "blazed the trail" for all of the health departments' new preventive programs. But, unlike their narrowly focused critics, they had possessed the wisdom to see the value of caring for the sick as a means of gaining access to families in greatest need of health education. Were the assertions of health officers that visiting nurses were not public health nurses made, they wondered, "to keep the visiting nurse in her place, outside the sphere of public health work?" If so, these efforts were in vain, for the visiting nurse was as much a public health nurse as any nurse employed by the health departments.44-47

By the 1920s, many nursing leaders were campaigning for the creation of an institutional framework that would allow the public health nurse to care for both the healthy and the sick. Realizing that separating the curative and preventive functions of the public health nurse had been a mistake, they argued for an "amalgamated" organization that would unite both the voluntary and publicly funded agencies.26 Even though these views were substantiated in numerous demonstration projects and major reports throughout the 1920s and 1930s, nurses gained few allies in their efforts to create such agencies. In most communities, relationships between these organizations remained haphazard, with gaps and duplication in services the inevitable outcome.33,48,49

With health departments, school health services, and visiting nurse associations providing a perplexing assortment of both curative and preventive nursing services, the meaning of public health nursing became increasingly obscure to both its practitioners and the public.48,50 The legacy of this dilemma still haunts contemporary public health nursing.51
Domain of Public Health Nursing

Thus, during its first 50 years, the domain of the public health nurse came to include almost every health aspect of life from the care of the sick to the prevention of disease. Unmistakably, to the public and voluntary agencies who sought their services, these nurses seemed an economical and appropriate way to help the poor. By the late 1920s, however, public health nursing had reached a turning point. From the perspective of the visiting nurse associations, the circumstances that had created the need for their organizations 20 years before were simply no longer of major concern to most communities. With fewer immigrants, declining death rates from infectious diseases, and the growing centrality of the hospital, the work of the visiting nurse seemed increasingly inconsequential. While they fought for a role in the evolving health care system, most had little success. Despite visiting nurse associations often-stated interest in extending their services to the whole community—sick, well, rich, and poor—their clients remained the poor and their major programs remained the care of the sick at home. In contrast to the experience of most visiting nurse associations, public health nursing within official agencies was undergoing a period of steady expansion. By 1924, with 54 per cent of all public health nurses working for official health agencies, it seemed inevitable that these organizations would remain the major source of employment for the field.

But health departments and boards of education were not managed like visiting nurse associations, as a cooperative effort of ladies and nurses guided, of course, for the most part by the nurses. In contrast, the work of the public health nurse in these organizations reflected more the policy of their organization or desires of the health officer than the "visions" of the nurses. This break with custom and loss of authority was, not surprisingly, of great concern to many leading public health nurses. While the leadership contin-

ued its campaign for the creation of a publicly funded comprehensive nursing service, the concerns of nurses in most official agencies were confined to the teaching of prevention.

Thus, within both public and voluntary organizations, public health nurses found it increasingly difficult to create the kind of institutional setting that would allow them to offer every kind of nursing service to patients in their homes. Despite their failed ideal, public health nurses went on caring for at least some of the public—in sickness or in health—but rarely the same nurse for both.

ACKNOWLEDGMENTS

This study was supported in part by American Nurses' Foundation, Nurses' Educational Funds, Inc., and the Division of Nursing of the US Department of Health and Human Services, grant #NU-05087. Photographs, except where noted otherwise, were provided by the Board of Managers of the Visiting Nurse Society of Philadelphia, founded in 1886 and the antecedent of Community Home Health Services of Philadelphia.

I wish to thank Charles Rosenberg and Joan Lynaugh for their critical review of this manuscript. I am especially grateful to Susan Revery for her support and comments.

REFERENCES

18. Their Health is Your Health, a fund raising booklet for Henry Street Nurses' Settlement. New York, 1934.

NIAD/NCl Establish Repository of Biological Specimens for AIDS Research

The National Institute of Allergy and Infectious Diseases and the National Cancer Institute have developed a repository of biological specimens from homosexual men. The specimens were collected through contracts with five major US universities for studies of the natural history of acquired immune deficiency syndrome (AIDS). Information about applying for collaborative use of these specimens and pertinent epidemiological data is now available from the Project Officer. For further information, contact Project Officer, AIDS Repository, Epidemiology and Biometry Section, National Institute of Allergy and Infectious Diseases, Westwood Building, Room 739, National Institutes of Health, Bethesda, MD 20205. Tel: 301/496-7065.

ADVERTISERS’ INDEX

American Journal of Public Health October 1985

American Foundation for the Prevention of Venerable Disease, Inc. ................................. 1135
Agency: Harris Advertising ................................. 1135
American Journal of Epidemiology ................................. 1142
Agency: Sussman and Sugar, Inc. ................................. 1147
Appleton Century Crofts ................................. 1143, 1144
Agency: Rolf Werner Rosenthal, Inc. ................................. 1127
Burroughs Wellcome Co. ................................. 1150
Agency: CSC Advertising ................................. cover 3
CARA Corporation ................................. cover 3
Agency: Scientific Marketing Services, Inc. ................................. 1150
Conceptual Software ................................. 1150
Agency: HL Advertising ................................. 1149
Eckstein Bros., Inc. ................................. 1149
Global Health Systems ................................. 1130
Agency: IPL Marketing Services, Inc. ................................. 1148
Inter Pacific Tours International ................................. 1148
Mead Johnson ................................. 1121, 1138
Agency: Bolaro, Inc. ................................. 1121, 1138

Merieux Institute, Inc. ................................. 1124, 1125, 1126
Agency: Baxter, Gutian and Mazzei, Inc. ................................. 1149
New York Heart Association, Inc. and Heart Fund ................................. 1149
National Spa and Pool Institute ................................. 1148
Pfifpharmecs ................................. 1136, 1137
Agency: S. J. Weinstein Associates, Inc. ................................. cover 2
Reed and Carrick ................................. 1140
Agency: M.E.D. Communications ................................. 1152a, 1152b, 1152c, 1152d, 1153, 1154
Roche ................................. 1128, 1129, 1145
Agency: S. J. Weinstein Associates, Inc. ................................. 1149
Rubin Associates ................................. 1149
Agency: Howard Swink Advertising ................................. 1149
Spectrum Films ................................. 1128, 1129, 1145
Agency: Henry E. Salloch ................................. 1149
Smith Sternau ................................. 1139
Agency: S. J. Weinstein Associates, Inc. ................................. 1140
Norcliff Thayer ................................. 1140, 1141
Agency: Carrafielo, Diehl and Associates, Inc. ................................. 1142
The University of Michigan Press ................................. 1142
Agency: The Michigan Collection ................................. 1151, 1152
Wampole ................................. 1151, 1152
Agency: Rolf Werner Rosenthal ................................. cover 4
Wyeth Laboratories ................................. 1146
Agency: Kallir, Philips, Ross, Inc. ................................. 1146
Youngs Drug ................................. 1146
Agency: Poppe Tyson, Inc. ................................. 1146

AJPH October 1985, Vol. 75, No. 10 1161
This article has been cited by:

1. Mary K. Canales, Denise J. Drevdahl. 2014. Community/public health nursing: Is there a future for the specialty?. *Nursing Outlook* 62:6, 448-458. [Crossref]


5. Judeen Schulte. 2000. Finding Ways to Create Connections Among Communities: Partial Results of an Ethnography of Urban Public Health Nurses. *Public Health Nursing* 17:1, 3-10. [Crossref]

6. M Jenkins. 1998. On nurses. *American Journal of Public Health* 88:1, 135-136. [Citation] [PDF] [PDF Plus]


8. Linda Weiss, Jan Blustein. 1998. Weiss and Blustein Respond. *American Journal of Public Health* 88:1, 136-136. [Citation] [PDF] [PDF Plus]


10. M Brady. 1998. Norplant coercion. *American Journal of Public Health* 88:1, 136-137. [Citation] [PDF] [PDF Plus]


14. M E Salmon. 1993. Public health nursing--the opportunity of a century. *American Journal of Public Health* 83:12, 1674-1675. [Citation] [PDF] [PDF Plus]


21. D Grembowski. 1985. Survey questionnaire salience. *American Journal of Public Health* 75:11, 1350-1350. [Citation] [PDF] [PDF Plus]