Cultivating *Constituencies*

The Story of the East Harlem Nursing and Health Service, 1928–1941

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I examine the history of the East Harlem Nursing and Health Service in New York City from its beginnings as a demonstration project in 1922 to its closing in 1941. I explore the less tangible goals, needs, and ambitions of the many different constituents that paid for, delivered, and received health care services. I place these goals, needs, and ambitions as critically important drivers of ultimate success or failure. The East Harlem Nursing and Health Service gained international fame among public health leaders for its innovative and independent nursing practice and teaching. However, it ultimately failed because its commitment was to a particular disciplinary mission that did not meet the needs of the constituent communities it served. From 1928 to 1941, the service focused more on the educational advancement of public health nursing and less on addressing the real health care needs of those in East Harlem. *(Am J Public Health*. 2013; 103:988–996. doi:10.2105/AJPH.2012.301088)

ON MARCH 10, 2010, PRESIDENT Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). Seven months later, a key feature of the bill, the Center for Medicare and Medicaid Innovation, opened its doors. Whereas the ACA looks to restructure key features of the US health care system, the Innovation Center will serve as an incubator of new ideas to deliver and pay for care that will improve quality and decrease costs. To this end, its $10 billion budget sets in motion demonstration projects to increase access to high-quality, cost-effective, coordinated health care for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program. Its charge is to rigorously and rapidly assess the progress of the demonstrations and to replicate those with a "high return on investment" in communities across the country. Its most recent initiative, Strong Start for Mothers and Newborns, calls for demonstration proposals that can be scaled up to national initiatives that will reduce early elective deliveries, test new approaches to prenatal care, and improve outcomes for mothers and babies.[1]

The Center for Medicare and Medicaid Services (CMS) has a 30-year history of supporting demonstration projects, most recently in disease management, care coordination, and value-based payment systems.[2] It has an equally long history of policy and practice evaluations to consider the metrics of success and failure. However, demonstration projects in health care in the United States predate the initiatives of the CMS. I turn to one such nurse-led project, The East Harlem Nursing and Health Service, in New York City in the interwar years. The initial five years of its service, a demonstration project to test feasibility from 1922 to 1927, was a resounding success. Linking practice and research, it provided the quantitative data that definitively established the best way to organize the practice of public health nurses.[3] It also provided data on the actual costs of visiting nursing services, thus allowing public health nursing associations across the country to anticipate the higher cost of postpartum and sick (morbidity) nursing care when constructing their budgets. Buoyed by this success, the demonstration project institutionalized its work in 1928 by reconstituting itself as the East Harlem Nursing and Health Service. The service ultimately failed: it lost its financial support, and, without ties to any of the city's public or private institutions, it closed in 1941.

It would be easy to tell the East Harlem story as a conventional "rise and fall" narrative in which nursing's ambitions failed to gather the sustained resources necessary to implement its vision of care. But a richer historical understanding of why and how some projects succeeded and others failed allows us to move beyond the clinical and economic metrics that have dominated, and will continue to dominate, the evaluations of the Innovation Center's demonstrations. It allows us to understand the less tangible goals, needs, and ambitions of the many different constituents that paid for, delivered, and received health care services. And it allows a perspective that places these goals, needs, and ambitions as critically important drivers of ultimate success or failure. The East Harlem Nursing and Health Service gained international fame among public health leaders for its innovative and independent nursing practice and teaching. Yet it ultimately failed because its commitment was to a particular disciplinary mission that did not meet the needs of the communities it served. From 1928 to 1941, the service focused more on the educational advancement of public health nursing and less on addressing the real needs of constituents in its East Harlem home.

THE PROBLEM OF CARE COORDINATION AND CONTROL

In the immediate aftermath of World War I, contemporaries recognized New York City's place at the epicenter of the public health world. Under the prewar public health leadership of Hermann M. Biggs, the city attracted international attention for its school health, immunization, tuberculosis control, and clean milk reform initiatives. They also recognized the city's place at the epicenter of the nursing world. Institutions such as the Visiting Nurse Service (VNS) at the Henry Street Settlement House captured the public's imagination by sending trained nurses into the homes of the sick poor; Teachers College at Columbia University exemplified the discipline's aspirations to higher forms of education by enrolling nursing educators, administrators, and public health nurses from around the globe in collegiate degree granting programs.[4]

But for all its successes, New York City still faced seemingly intractable health issues among its poor, working-class, and immigrant families. These included high maternal and infant mortality rates, poor prenatal care, and insufficient attention to the prevention and treatment of tuberculosis. In ways that predate what we now describe as the social determinants of health, New York City's public health leaders clearly understood the relationships among the conditions in which families lived, the material resources available to them, the access to education for their children, and their health status. Issues of access to and equity in 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—issues that sound frighteningly similar to those experienced by today's families from disadvantaged and minority backgrounds—remained highly problematic.[5]

The recently won World War had seemingly proved the power of coordination in effectively and efficiently meeting the extraordinary demands of military and civilian populations. Consequently, at a time when most Americans entered a health care system dominated by the private physician–patient relationship, the idea of "coordination" filtered into postwar health care delivery dialogues about how private and public health and welfare organizations could meet the needs of the poor and dispossessed. In particular, the American Red Cross reconfigured its peacetime mission and charged local chapters with bringing together leaders in government, philanthropy, and business to create community-based "health centers" that could more efficiently coordinate the delivery of health and social welfare services to those in need.

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The New York County Chapter of the Red Cross chose East Harlem as the site of its health center. Covering 87 city blocks that stretched from Third Avenue to the East River and East 99th Street to the Harlem River, East Harlem was home to 112 000 predominantly Italian and Italian-American individuals, including 3200 infants, 16 000 preschool children, and 27 000 school-age ones.[6] A few men worked as skilled artisans, but most were employed as laborers, factory hands, or petty tradesmen; one

third of its women had to supplement their families' incomes by homework making paper flowers or sewing factory-consigned garments.[7] East Harlem residents were desperately in need of better health and social welfare services. 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 1000/year) mortality rate compared with 14.7 in the city; during the same time period, the mortality rate for their babies was 100.6, versus 83.2 for the city as a whole.[8]

In the early 1920s, New York City's public health nursing leaders decided that their contribution to the search for solutions would be a special nursing demonstration project within the boundaries of the health center in East Harlem. Their work would be one of care "control," not merely coordination. The four private agencies that provided nursing care in East Harlem—the Henry Street VNS, which focused on nursing the sick in their homes; the Maternity Center Association, which provided maternity care and education; the Association for Improving the Conditions of the Poor, which supported tuberculosis nurses; and St. Timothy's League of lay women, who supported the work of nurses—would pool their resources, personnel, and dollars into one umbrella organization with its own governing board.[9] A matching grant from the Rockefeller Foundation's Laura Spelman Rockefeller Memorial gave it the unparalleled opportunity to design and implement a comprehensive program of illness care and maternal–child health education in a smaller geographic area of approximately 40 000 individuals within the East Harlem district. It also provided the statistical support for carefully designed research projects that might influence models of public health nursing practices across the country and, indeed, across the globe.

The demonstration project flourished under the direction of Grace Anderson, formerly head of the Municipal Nursing Service in St. Louis, Missouri. It continued the VNS's practice mission of providing bedside nursing to sick residents in their own homes. It strengthened its outreach to pregnant women, encouraging medically supervised births, preferably in hospitals, but providing both prenatal and postpartum care in homes. It started new health education practices for preschool children, a group often overlooked by initiatives that centered on infants and school-age children.[10] By 1927, it had answered all calls for bedside nursing, had reached 30% of all expectant mothers, and had 40% of preschool children under its health supervision.[11]

Just as important, the demonstration's research mission found answers to two of the most pressing issues facing public health nurses across the United States. The first addressed the organization of public health nursing practice. Which was more efficient and effective: generalized nursing where one nurse treated all the nursing needs in a defined neighborhood, or specialized nursing where an individual built expertise in a defined practice area such as tuberculosis, maternity, or school nursing? It launched a well-designed comparative study of the effectiveness of generalized versus specialized nursing with carefully matched East Harlem neighborhoods organized to receive care either from an array of specialized nurses or from one nurse who had specialty consultants available to her at the health center. The final published data showed that generalized nursing practice had outcomes as good as more specialized ones and was more efficient and cost-effective.[12]

The second question dealt with the costs of different kinds of public health nursing practices. The demonstration reworked its record-keeping system to include the length of time of nursing visits to enable another study that would compare the costs of different kinds of nursing home visits. Throughout 1924, its nurses kept detailed records of whom they visited, for what reasons, how long they spent in the home, and how long they spent with other tasks such as travel, clinic work, and record keeping. Not surprisingly, the data showed that postpartum care—care that also involved that of newborns—cost the most per visit ($2.96) because of the length of time involved (46 minutes/visit); sickness care followed, costing $1.62 per 25-minute visit.[13] Surprisingly, the cost of teaching public health nursing students was not recouped by the services they rendered.[14] Students were expensive.

And students were an increasing presence in the demonstration. As private visiting nurse associations and municipal public health nursing agencies grew in the 1910s and 1920s, it became apparent that the inpatient hospital-based diploma programs in which the overwhelming majority of nurses received their basic training could not provide the background and clinical experiences needed for successful

public health nursing practice. In some places, private and public agencies themselves provided postgraduate educational experiences; in others, colleges and universities offered first certificate and later degree programs in public health nursing theory and practice.[15] But such programs remained limited, a consensus on the curricular content remained problematic, and the available practice sites remained few and far between.

By early 1927, when Anderson and her governing board paused to review the demonstration's accomplishments, it became clear that a teaching mission had slowly grown up alongside its practice and research ones. Over the previous years, it had hosted increasing numbers of public health nurses from around the country, international nurse fellows supported by the Rockefeller Foundation, and postgraduate public health nursing students from Teachers College at Columbia University. As they looked to the future, Anderson and her colleagues remained committed to continuing formal nursing practice, but they also looked toward a more visible leadership role in public health nursing education. The nurses at East Harlem hoped to forge a unique and model relationship with Teachers' College for the postgraduate education of diploma-trained nurses who sought public health nursing positions.[16] They also wanted to take curricular leadership and fundamentally change the way nurses thought about their patients and their patients' needs. Rather than learning only about the theory and health content needed for public health nursing practice, they wanted to teach nurses about the psychological context in which the content would be delivered.[17] The governing board of East Harlem approached the Rockefeller Foundation for a new grant in support of a new mission of practice and teaching.

NURSING AND THE ROCKEFELLER FOUNDATION

The governing board's request came at a turning point in the Rockefeller Foundation's nursing policy. The foundation had always been clear that its support of nursing was directly connected to its support of medical education and public health both in the United States and abroad.[18] From its initial work on hookworm control in the American South in the early 20th century, it had developed global programs in medical education, research, and public health. Its commitment to help rebuild the public health infrastructure of war-torn Europe crystallized what, for the foundation, was the critical issue related to public health nursing: what kind of education did a public health nurse need for effective practices coordinated by medical public health officers? The foundation had supported prelicensure collegiate nursing education programs in the United States and abroad; it had hoped that these programs, freed from the needs of hospitals that used the existing diploma training programs to staff their inpatient wards, would create new curricula and training models that would turn young women into fully functioning public health nurses in as little as two years. Foundation officials, however, found themselves increasingly frustrated. These schools, they believed, produced nurses who could care for the sick but who needed additional education on the principles and practices of public health nursing.[19]

In 1927, the Rockefeller Foundation remained sympathetic to the actual work of the nurses in East Harlem, and gave them another five-year grant to continue their practice in the community.[20] But despite the nurses' resolute claims that the practice and teaching missions of East Harlem were "inseparable," the foundation refused to support their new educational mission. To do so would not only contradict its stated policies on funding only prelicensure education, but also mean abandoning foundation nursing schools in Europe that were trying to create their own forms of undergraduate schools of public health nursing. The Milbank Memorial Fund, sponsoring another health demonstration project in the Bellevue-Yorkville section of the city that emphasized public health nurses' roles in teaching families, agreed to fund the teaching mission of East Harlem. The East Harlem nurses, secure in more support from the Rockefeller Foundation for its practice mission and in the continuing resources of the four cooperating nursing agencies, set about to create a formal "family nursing service." In 1928, they brought the demonstration part of its work to a close, and reorganized as the East Harlem Nursing and Health Service.

A NEW APPROACH TO NURSING

There were some substantive differences between the earlier demonstration and the new East Harlem Nursing and Health Service. The service now adopted a more self-consciously independent, interdisciplinary

and intertwined practice and teaching mission. Anderson, in her 1931 summary report to the Rockefeller Foundation, spoke directly to its significant success in "pooling of professional knowledge and skills in working out the essentials of a family health program for the community."[21] Only in East Harlem could students' observation and practice be directly correlated with theoretical instruction in education, psychology, sociology, nutrition, mental hygiene, and social casework. They learned about family relationships in class and focused on improving them in practice; the service provided students from around the globe with a "social laboratory" in which new experiences were translated into new principles and practices. Homer Folks, the prominent secretary of the New York Charities Aid Association and chair of the service's governing board, reiterated this in 1932. As he reported to the Rockefeller Foundation,

> The Nursing and Health Service has disregarded the barriers that exist between professional groups and has brought experts in nutrition work, in mental hygiene, in social work, and in education into a close working relationship with nurses and physicians to the end that a more complete service may be rendered to the people of the community.[22]

This had significant practice implications. What had once been an "integrated individual service" had by 1934 become an "integrated family service."[23] This required a change not only in focus but also in methods: traditional public health nursing checklists had evolved into narrative family data sheets transcribed by stenographers; health clinics and conferences at the center became places where a mother would bring all her children at one time rather than sequentially to identified infant or preschool health screenings. But, most of all, it meant more aggressively promoting the mental hygiene aspects of a new nursing role to a wider audience.

The 1920s and 1930s witnessed a resurgence of the mental hygiene movement that offered a potential new knowledge base—psychoanalytic theory—that leading nurse educators hoped would buttress nursing's claim to specialized knowledge and independent practice. Two threads consistent with the mental hygiene movement ran through East Harlem's new approach to family nursing. First, there was no longer a notion of a "normal" family. As its mental hygiene consultant, Sybil Pease, wrote, the pervasive idea of "adjustment" as a signifier of mental health now meant that "to be normal is to have a problem of adjustment to work out."[24] All families needed mental hygiene help. They needed advice "about innumerable things from a friendly person in whom one has confidence."[25] And patients would necessarily have that confidence in one who nursed the sick when she returned to tell an expectant mother about infant care feeding and the best weaning practices that would encourage both excellent nourishment and emotional independence. The stakes seemed high. As Pease concluded in a speech to public health nurses in Canada in 1934, the public health nurse directly affected the process of family building. And in a successful family,

> People who have known love and security and a chance to be independent in their first years are not likely to become insane or neurotic as adults; and because happy people do not commit crimes nor does a contented nation make war.[26]

At the same time, Anderson found herself constantly balancing a commitment to generalized nursing practice with the need to administer clinics organized around the medical specialties of the physicians who staffed them. Issues of timing, expertise, and personal preference presented constant challenges.[27] But it was worth it. "Because of its flexible program, freedom in experimentation, and its long-time contacts with families and individuals," Anderson reported to the foundation, the service did not need to restrict its mission to one purpose. The private visiting nurse agencies focused on nursing practice. The city's Public Health Nursing Bureau concentrated on teaching families. East Harlem bridged both missions. Hence the need: "The Nursing and Health Service offers a type of community service that can only be given by a private or voluntary agency." The Rockefeller Foundation disagreed, but it did acknowledge the value of the service's practice mission and agreed that a complete withdrawal of the support would be a "hardship" on the people it served.[28] It agreed to an additional, tapering four years of funding through 1936, and began helping in the search for an alternative institution that might support the service and allow it to continue.[29]

A CHANGING LANDSCAPE

"Hardship" scarcely captured conditions in the early years of the Great Depression. The Depression and the accompanying unemployment hit the East Harlem community early and

hard.[30] An impressionist 1931 survey of New York City's nurses and social workers reported "unusual and disturbing reports of suffering" and families delaying health care to pay rent and purchase food.[31]

The Depression had also taken its toll on private, voluntary agencies that could not meet overwhelming and legitimate needs for economic relief. In a complete reversal of numbers attending its opening in 1922, by the early 1930s, 98% of East Harlem families needing relief were supported by first state and later federal dollars; only 2% now received support from private agencies.

However, those same federal dollars undercut the service's community focus. Fiorello La Guardia, the past congressional representative of East Harlem and now mayor of New York City, was committed both to public health—his first wife and their child had died of tuberculosis—and to the new federal construction dollars available through the Works Progress Administration. Under his watch, the city secured millions of dollars to expand dental screening programs and preschool health examinations, add public health nurses to the Health Department rosters, build hospitals, and eventually bring neighborhood health center to selected districts in the city. One of the first such centers was specially built in his own community of East Harlem in 1935.[32]

The city's own 1929 report, *A Health Inventory of New York City*, presaged the changing health care landscape. Constructed by well-known health care reformer Michael Davis, the inventory noted the problematic nature of the public and private care coordination that spurred the development of health demonstration projects across the United States in the early 1920s. But it also noted changes that he felt bode well for the future: the rise in the numbers of hospitals whose own outpatient clinics took health prevention and care coordination more seriously; the sharp increase in numbers of individuals across the city using these clinics; and the "dissolving" boundaries between private medical practice and public health promotion.[33] Davis was less enthusiastic than many about institutionalizing health centers like East Harlem. The entrance of hospitals as increasingly important institutions in the health care arena, he believed, had a "radical" effect on the delivery of home health care services and lessened the need to think about placing health centers in areas well served by these institutions and their growing outpatient departments.

Even the families that the East Harlem Nursing and Health Service was committed to serve were changing. By the mid-1930s, because of immigration restrictions, 60% of the White population served by the East Harlem Nursing and Health Service was born in the United States, 30% was born abroad, and 10% was Black and Hispanic, the latter group becoming an increasing presence in East Harlem. The service had noticed a decreasing demand for Italian translators.[34] Birth rates to young White parents had plummeted more than 50%, and families were growing smaller in size, a trend abetted by a neighborhood birth control clinic and noted with approval by the East Harlem nurses, who felt that the children received more and better attention. Infant mortality had fallen to 56 per 1000, compared with 74 per 1000 in 1923; maternal mortality, however, remained more intractable: its prevalence remained the same as in 1923.

And, almost overnight, hospitals had replaced homes as the preferred site of births and physicians had replaced lay midwives as the preferred attendant. Until 1927, 85% of births in New York City had been in the home; by 1934, 65% occurred in hospitals. "Young mothers," Anderson reported to her governing board, "look upon hospital care quite differently than did their foreign born parents."[35] East Harlem's one outpatient medical clinic had closed in 1933 as physicians' care now came though hospitals, hospital-based outpatient clinics, or private practice. Now, the East Harlem nurses' first responsibility when called for a prenatal visit was to ensure that mothers registered at the hospital in which they hoped to deliver as early in their pregnancy as possible. The nurses would then begin their own prenatal work, monitoring urine and blood pressures and teaching elements of newborn care.

The service itself was floundering. For the first time, it found itself with a $5000 deficit as it closed the 1935 fiscal year.[36] Despite repeated appeals, the last foundation grant of $10 000 would begin, as planned, on December 1, 1935, and end on November 30, 1936.[37] Mary Beard, the assistant director of the Rockefeller Foundation's Division of Nursing Education, did get the foundation to pledge $5000 to maintain some home and clinic-based care in 1937 and 1938 while the service developed a plan for its transfer to a new health center run by

New York Hospital—Cornell Medical Center.[38] But this plan never amounted to more than a wish; the medical center had its own training school to meet its needs for inpatient and outpatient nursing. The East Harlem Nursing and Health Service limped along for the next few years, until it acceded to the inevitable. A personal and rather terse letter from Margaret Nourse, president of St. Timothy's League and longtime supporter of the service, to the foundation in January 1941 acknowledged that "your generosity and real interest in this project entitles you to know of the imminent shutting down of this teaching centre [*sic*]."[39] An innovative nursing service and, as Nourse inadvertently emphasized, disciplinary teaching service, which had hoped to transform the practice and teaching landscape of public health nursing, had come to a close.

SHUTTERING THE SERVICE

In the eyes of the Rockefeller Foundation, it was this very inventiveness and independence that spelled the demise of the East Harlem Nursing and Health Service. Thomas Appleget, the Rockefeller Foundation liaison to the service, argued that its uniqueness was its problem. It was neither a city health service nor an affiliated unit of the "great medical centers." It was providing a "notable community service," but that which made it renowned also made it vulnerable. East Harlem had been, in his mind, "rather stubborn in its independence." It had kept itself free from relationships with hospital-based schools of nursing, whose inevitable and insatiable demands for inpatient care would have compromised its ability to identify, experiment with, and solve what it saw as problems uniquely within the domain of public health nursing. And it had steered clear of the politics of public health. As Katherine Tucker, director of the Department of Nursing Education at the University of Pennsylvania, pointed out in her letter of support for the continued existence of the service, it had fewer "entangling alliances" and never suffered from "the periodic upheavals that usually occur in most community services."[40] This, Appleget acknowledged, led to the excellent work of the service—and to the question of survivability once the last remnants of funding from the foundation stopped in 1937.[41]

Certainly, the dislocating social and economic conditions of the 1930s affected the work of the service. But they equally affected the work of affiliated organizations that survived through retrenchment and reorganization. The Association for Improving the Conditions of the Poor had to merge with the city's other private social welfare agency, the Charity Organization Society. The new organization, the Community Service Society of New York, held a less prominent place as public programs replaced private dollars as the primary source of relief. The Henry Street VNS eventually had to split its neighborhood settlement house work from its work providing nursing care to the sick in their homes. Both survived, struggling through the 1940s and 1950s until the federal health and welfare programs of the 1960s brought renewed vitality to their missions. They had met the real health and welfare needs of their patients before the Depression and would continue to do so afterward.[42]

The practice mission of the East Harlem Nursing and Health Service did meet the needs of many of its patients. Its "new approach to health work" developed new procedures that addressed the health needs of preschool children, experimented with the organization of nursing practices, and integrated knowledge from mental hygiene into all aspects of health work. Its research established the role of the public health nurse as a "general practitioner," maintaining high standards of work that integrated the specialized services of sickness nursing, maternal and infant nursing, and tuberculosis nursing.[43] Its eminence was recognized by leaders in public health nursing who worked for agencies also trying to do the same for their patients and nurses. In a series of letters solicited by Grace Anderson in her last attempt, in 1937, to save the service, Marguerite Wales, former director of nursing at the Henry Street VNS and now a consultant in nursing education to the W.K. Kellogg Foundation, pointed out that "nowhere else have specific problems in public health benefited from the group thinking of experts not just thinking about but actually working to solve problems."[44] Elizabeth Fox, former director of nursing for the American Red Cross, spoke from her new role as executive director of the Visiting Nurse Association of New Haven:

> We, the agencies in the field, look to East Harlem as our research laboratory and experimental station because we are able to take over some of its findings and adapt them to our situations.[45]

Yet these nurses spoke to the earlier demonstration's commitment to practice and research. The later East Harlem Nursing and Health Service, by contrast,

took practice and teaching as its domain. It may have met the needs of many of its patients, but it served the needs of a discipline seeking to institutionalize the place of public health nursing through curriculum standards and supervised clinical learning opportunities. The service, in fact, lost its way when it became enamored with a teaching mission that found little support among its most important external constituents. It understood that the Rockefeller Foundation had no interest in graduate public health nursing education. Still, its supporters argued to the foundation that sustaining the practice and teaching missions of the East Harlem Nursing and Health Service was "one of those decisions which sometimes have to be made which are exceptions to the rules." Mary Beard pleaded with foundation officers that "public health nurses cannot be educated without such a teaching field."[46] Yet the service continued to ignore the need for financial sustainability that was the hallmark criterion of Rockefeller Foundation support.

Moreover, the service's practice mission had gravitated toward families most receptive to its vision of public health nursing practice. As Anderson wrote in a final 1937 plea to sustain the service, it more "consciously" selected parents most responsive to teaching and guidance. Although it continued to attend to all families who experienced episodes of illness or the birth of a new child, "maximum help" was given to families of "more ability."[47] Yet rather than carry out research on new problems such as reaching out to other families most in need, the service now published pamphlets more akin to policy and procedure manuals than to hard data. These pamphlets were popular. The *East Harlem Health Workers Handbook on Infant Development, Care, and Training* (1932), *What Every Family Health Worker Should Know* (1934), and the *Handbook on Child Care* (1937) provided public health nurses across the country with the physical and psychological assessment data collected by the service's nurses, with the forms used to collect and order data, and with the pamphlets left with families for their continued education. These were a valuable and valued service to the discipline of public health nursing, but they offered little innovation. Instead, they reflected the practices of the more progressive Visiting Nurse Associations in New York; Boston, Massachusetts; Chicago, Illinois; St. Louis, Missouri; Toronto, Ontario, Canada; and Baltimore, Maryland. And they incorporated little of the changing health care landscape, such as the increasingly prominent place of cancer and chronic illness on the public health agenda. Rather, East Harlem nursing practices reflected health care as progressive public health nurses wanted it to be—constructed within intimate personal relationships forged in homes and not in the more impersonal ones found in the increasingly central hospitals and health care centers.

The nurses at the East Harlem Nursing and Health Service, along with like-minded colleagues, opened public health nursing to interdisciplinary areas of knowledge long before such a practice was popular. They introduced mental health concepts into the practice of nursing long before they became engrained in nursing school curricula. They broadened their care to be more inclusive of families rather than individuals. And they were not alone in their problematic quest to institutionalize the practice and teaching of public health nursing. As historian Karen Buhler-Wilkerson points out, the 1920s and 1930s were periods of "self-analysis" for public health nursing, but it was a period when the field's own organizational reports all focused inward on the needs of the discipline rather outward on the needs of the community. They were reports that, in 1925, Susan Moore, associate editor of *Nation's Health,* the monthly newsletter of the American Public Health Association, termed "uninspirational."[48]

"The nurses at the East Harlem Nursing and Health Service, along with like-minded colleagues, opened public health nursing to interdisciplinary areas of knowledge long before such a practice was popular."

As we look forward to the Center for Medicare and Medicaid Innovation's call for demonstration projects such as Strong Start for Mothers and Newborns, projects central to nursing's knowledge and practice domains, we can remember the experiences of nurses in East Harlem as lessons about what might be most important. Disciplinary needs—be it East Harlem's role as a teaching center, or now nursing's wish to demonstrate the power of advanced practice nursing, or medicine's wish to lead medical homes—cannot be separated from the needs of constituent communities. These communities might be narrowly defined as the funders of demonstrations or more broadly defined as the people they serve. East Harlem succeeded when it joined

with constituents around the need to create meaningful knowledge about how to care for those at home and in the community. It failed when its mission of knowledge generation through research gave way to knowledge transmission through teaching because of a disciplinary commitment to training a new generation of practitioners from across the country and across the globe not shared by those outside its world. ■

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Endnotes

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19. Mary Beard's "Nursing Needs, 1937," RAC, RF, Record Group 3, Series 908, Box 15, Folder 165; see p.12 for retrospective analysis.

20. Addendum, January 4, 1927, RAC, RF, Record Group 3.1, Series 900, Box 19, Folder 137.

21. "The Teaching Service of the East Harlem Health Demonstration Service," April 1, 1928–October 1, 1931, RAC, RF. Record Group 1.1, Series 235, Box 1, Folder 13.

22. Homer Folks to Thomas Appleget, April 20, 1932, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 10.

23. "Community Service in 1934," p. 27, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 14.

24. Sybil Pease, "Mental Hygiene Functions of the Public Health Nurse," *Annals of the American Academy of Political and Social Science* 149 (1930): 180–183, quote on 182.

25. Sybil Pease, "New Frontiers in Public Health Nursing," *The Canadian Nurse* 25 (1933): 524–528, quote on 527.

26. Pease, "New Frontiers," 530.

27. "East Harlem Nursing and Health Service: A Progress Report," 1934, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 14.

28. Thomas Appleget to Homer Folks, May 10, 1932, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 10.

29. "East Harlem Nursing Service," May 9, 1932, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 9.

30. "Community Service in 1934," p. 27, RAC, RF, Record Group 1, 1, Series 235, Box 2, Folder 14.

31. Lillian Brandt, *An Impressionistic View of the Winter of 1930–1931* (New York, NY: Welfare Council, 1932).

32. Duffy, *The Sanitarians*, 260.

33. Michael Davis and Mary C. Jarrett, *A Health Inventory of New York City: A Study of the Volume and Distribution of Health Services in the Five Boroughs* (New York, NY: Welfare Council of New York, 1929), 36–39.

34. "East Harlem Nursing and Health Service: A Progress Report," 1934, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 14.

35. "Meeting of the Board of Directors, February 28, 1935," RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 11.

36. "Minutes of a Meeting of the Corporation in the East Harlem Nursing and Health Service," December 10, 1935, RAC, RF, Record Group 1, 1, Series 235, Box 2, Folder 15.

37. Appleget to Folks, June 24, 1935, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 11.

38. Mary Beard, "The East Harlem Nursing and Health Service," December 11, 1935, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 11.

39. Margaret Nourse to Raymond Fosdick and Thomas Appleget, January 15, 1941, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 12.

40. Katherine Tucker to Grace Anderson, March 10, 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16.

41. Memo by Appleget of visit of Folks, November 23, 1937, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 10.

42. Karen Buhler Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore, MD: Johns Hopkins University Press, 2003), 170–179.

43. "The East Harlem Nursing and Health Service: Fifteen Years of Cooperative Endeavor: Should It Go On?," 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16.

44. Marguerite Wales to Grace Anderson, March 19, 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16. Other letters of support came from Lillian Hudson of Teachers' College (April 12, 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16) and Amelia Grant, director of the Bureau of Nursing in the Department of Health (Grant to Anderson, May 10, 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16).

45. Elizabeth Gordon Fox to Grace Anderson, April 1, 1937, RAC, RF, Record Group 1.1, Series 235, Box 2, Folder 16.

46. "Note to Dr. Russell," March 15, 1935, RAC, RF, Record Group 1.1, Series 235, Box 1, Folder 11.

47. "The East Harlem Nursing and Health Service: Fifteen Years of a Cooperative Endeavor."

48. Buhler-Wilkerson, *No Place Like Home*, 172.