

Bringing Care to the People: Lillian Wald's Legacy to Public Health Nursing

ABSTRACT

Lillian Wald invented public health nursing in 1893, making this year the field's centennial. One of nursing's visionaries, Wald secured reforms in health, industry, education, recreation, and housing. This historical inquiry examines three of Wald's critical experiments, each of which illuminates the past of public health nursing and its contemporary dilemmas: invention of public health nursing itself, establishment of a nationwide system of insurance payments for home-based care, and creation of a national public health nursing service. (*Am J Public Health*. 1993;83:1778-1786)

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Introduction

One hundred years ago, Lillian Wald invented the term "public health nurse," hoping to prescribe a new role for nurses who visited the homes of the sick poor. As she recognized that sickness should be considered within its social and economic context, Wald's remedies for seemingly overwhelming problems were both innovative and pragmatic. What she called "our enterprise [of] public health nursing" was not an isolated undertaking, nor was she a lone American heroine.¹ Wald's paradigm for nursing practice was based on knowledge gained during 2 decades of experience in visiting nursing and owed much to the Progressive reform and public health movements of the turn of the century. Historically, Wald is often characterized as a visionary whose accomplishments are legendary. Due credit must be accorded, however, to thousands of public health nurses who struggled to create institutional settings that would allow them to practice. This combined effort changed the course of nursing history.

In the following pages I examine Wald's three critical experiments, all of which were conducted at the turn of the last century and all of which illuminate the past of public health nursing and its contemporary dilemmas: the invention of public health nursing itself, the establishment of a nationwide system of insurance payments for home-based care, and the creation of a national public health nursing service. Each is examined at two time points: inception and post-1920. By the early 20th century, the successes and failures of Wald's experiments were increasingly apparent. The outcome of each is a powerful reminder that nursing's ability to care for the public's health is often determined by public sentiment, nursing's access to institutional power, and the match

between what nurses do and the nature of health care problems of the time. Finally, lessons from the past are considered, not to define a readily transferable model of practice, but to identify new directions for contemporary public health nurses seeking innovative, cost-effective, and practical solutions to our current health care crisis.

The Experiments at Inception

The Invention of Public Health Nursing

A century ago, American cities were dirty, crowded, and unhealthy places to live. The fluctuating, dramatic, and often frightening presence of infectious disease was a source of great public concern. As popular knowledge of the germ theory of disease spread, urban dwellers came to realize that individual health depended to some extent on the health of the population generally. Not only was illness a major cause of destitution, but the infectious diseases contracted by poor people appeared to threaten the well-being of middle- and upper-class urban dwellers as well.²

In response to these circumstances, hundreds of community organizations hired trained nurses to care for the sick poor in their homes. The image of the nurse climbing tenement stairs to save the poor from illness struck the fancy of a

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wide variety of social reformers. By the turn of the century, women's clubs, church groups, mission societies, hospitals, charity organizations, tuberculosis associations, health departments, settlement houses, and visiting nurse associations across the country were sending visiting nurses to care for the sick and, in doing so, protecting the public from the spread of infectious disease. Such diversity of private and public sponsorship reflected both an upper-class fear of the diseases associated with the "dangerous classes" and a recognition of the trained nurse as an economical and practical solution to the complex problem of "elevating" poor, often immigrant families to a more ordered, healthier existence.³

It was during these turbulent times that Lillian Wald founded the influential Henry Street Nurses' Settlement and authored the term "public health nurse." Wald chose to enter the nursing profession at the age of 22. Finding her life of society, study, and housekeeping duties unsatisfying, she voiced a desire for serious, definite work. Anxious to see life in all its aspects, Wald left her home in Rochester and entered the New York Hospital School of Nursing in the city of New York. Following her graduation in 1891, her first position at the New York Juvenile Asylum left her dismayed about the institutional care of children and discouraged that nurses could not produce institutional change.⁴

After so disheartening a start, Wald's story really begins in the late winter of 1893, when she learned that a Sabbath school for immigrants needed a course in home nursing. Unaware of the work of those who had preceded her to New York's lower East Side and even more ignorant of life's realities for most immigrants, Wald agreed to establish and teach the class. A call for help to the home of one of her immigrant students, Mrs Lipsky, would have significant impact on public health in the United States. Wald later wrote of being guided by Mrs Lipsky's young daughter through "evil smelling" streets, past open courtyard "closets," up slimy steps of a rear tenement, and finally into the sickroom:

All the maladjustments of our social and economic relations seemed epitomized in their brief journey and what was found at the end of it. The family to which the child led me was neither criminal nor vicious. Although the husband was a cripple, one of those who stand on street corners exhibiting deformities to enlist compassion, and masking the begging of alms by a pretense of selling;



Lillian Wald at the height of her career, ca. 1910. Reprinted with permission of the Visiting Nurse Service of New York.

although the family of seven shared their rooms with boarders . . . and although the sick woman lay on a wretched, unclean bed, soiled with a hemorrhage two days old, they were not degraded human beings, judged by any measure of moral values.

In fact, it was very plain that they were sensitive to their condition, and when, at the end of my ministrations, they kissed my hands . . . it would have been some solace if by any conviction of the moral unworthiness of the family I could have defended myself as a part of a society which permitted such conditions to exist. Indeed, my subsequent acquaintance with them revealed the fact that, miserable as their state was, they were not without ideals for the family life, and for society, of which they were so unloved and unlovely a part.⁵

This experience was for Wald a baptism by fire. Rejoicing that her training in the care of the sick gave her an "organic relationship" with the community, she

and Mary Brewster, her comrade from nursing school, devised a plan to live in the neighborhood as nurses. To support their plans, they sought financial backing from Mrs Solomon Loeb, who had earlier sponsored the Sabbath school classes. Loeb and her son-in-law, Jacob Schiff, agreed to underwrite their enterprise for 6 months. Two years later, Schiff purchased the house on Henry Street, allowing Wald to have the space necessary to develop many of her unique ideas.⁶

Wald's biographer, Robert Duffus, maintains that she moved to the lower East Side with

no theories about economics, sociology or politics, little knowledge as to how people outside her own social group lived, no panacea to try out, no sweeping vision of the future . . . but she did have an imagination which enabled her . . . to put herself in other people's places.⁷



The work of the public health nurse. Reprinted with permission of the Starr Centre Association of Philadelphia, Center for the Study of the History of Nursing.

Despite claims of the “untrammelled and spontaneous character of [her] enterprise,” it can be reasonably assumed that Wald’s attendance at the meetings of the International Congress of Charities, Corrections, and Philanthropy at the Chicago World’s Fair just prior to her move to the lower East Side was indeed influential.⁸ At the congress, Wald met the women who had preceded her in community work in England and America. Of special significance were the nursing sessions, especially the paper by Florence Nightingale (in absentia), “Sick Nursing and Health Nursing,” outlining her plan for health visitors. For the first time, American visiting nurses and their supporters had the opportunity to discuss at length the pressing issues they faced with their English colleagues who had founded visiting nursing.⁹

Inspired by the congress, Wald and Brewster moved to the lower East Side in July 1893, thus joining the growing ranks of “new women.” Described as a revolutionary demographic and political phenomenon, the new woman was typically single, educated, and economically independent, a champion of professional visibility for women and an advocate of economic and social reform. Defying the rules of social propriety while retaining a place within their genteel world, these women sought and achieved considerable political power.¹⁰

Wald and Brewster arrived on the lower East Side during the 19th century’s

worse depression and immediately confronted disease, vermin, poverty, and the filth of crowded tenement homes. They recognized, however, that the sickness encountered in families had to be seen as part of a larger set of social problems. Recovery required much more than nursing care alone. Convinced that the degrading conditions generally associated with poverty existed only because people did not know better, Wald committed herself “to know and to tell.”¹¹

Wald’s practice among those without economic resources quickly convinced her that disease resulted most often from causes beyond individual control or escape, that treatments needed to be prescribed in an “all round way” with consideration for the social and medical aspects of the case; and that families should realize that outsiders would not carry the entire responsibility but rather were available for guidance concerning measures that might be taken to alleviate problems. Wald characterized this as service from the patients’ point of view. She believed public health nursing had to be practiced through democratic, neighborly, simple relationships if it was “to serve where poverty augments the misfortune of disease.”¹²

Wald claimed she chose the title “public health nurse” to place emphasis on the “community value of the nurse” whose work was built upon an understanding of the social and economic prob-

lems invariably accompanying patients’ ills. Free to explore and experiment while caring for her neighbors during frequent births, illnesses, and deaths, Wald began to mobilize an impressive, if disjointed array of services, from private relief agencies to the medical establishment itself. Creation of cooperative relationships with organizations as varied as hospitals and newspapers allowed her to provide patients with ice, sterilized milk, medicines, meals, and, most importantly, jobs. As word of the nurses’ work spread, hospitals, dispensaries, relief agencies, and private physicians became “believers” and referred neighborhood patients for skilled follow-up and teaching.¹³

Wald’s vision resulted in nursing practice that went beyond simply caring for families during illness to encompass an agenda of reform in health, industry, education, recreation, and housing. Whether patients’ problems were isolated and unusual or common to many was, according to Wald, important to know because the “technique for finding out” often led logically to the identification of an appropriate remedy. From the beginning, “every incident that seemed to have community bearing was noted and held in reserve” for such time as it could be broadcast to enable others with facilities for greater publicity to influence and educate public opinion toward “pricked consciences” and mutual responsibility.¹⁴

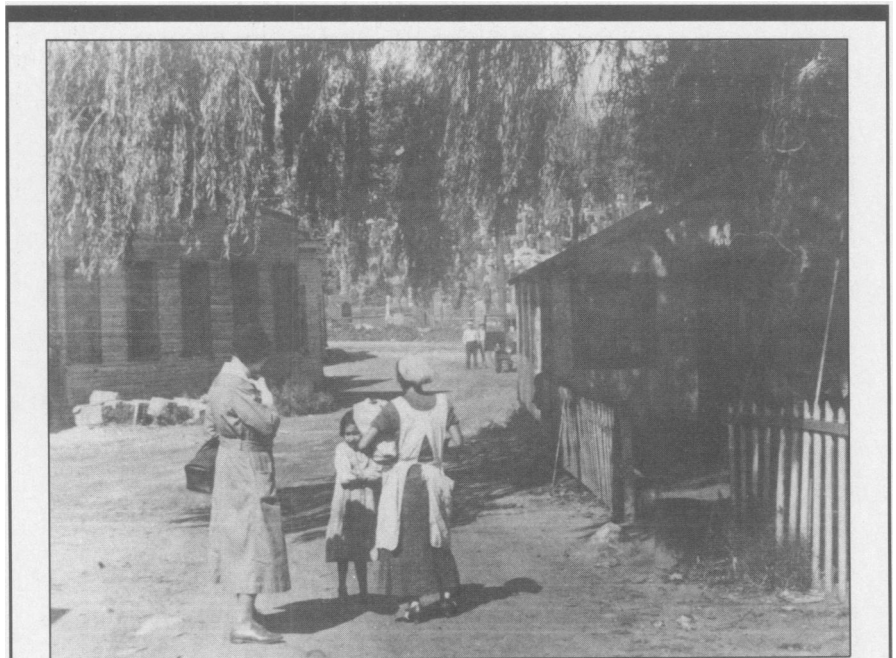
In 1895, the desire to create a larger and more formal organization made it necessary for Wald to move out of her tenement home into the nearby house that would become the Henry Street Nurses’ Settlement. At the meeting of the National Conference of Charities and Corrections, Wald solicited “zealous women” of talent, ability, and spirit to realize the privilege of joining their family. By 1910, the staff of 54 nurses ran a milk station, a convalescent center, three country homes, and several first aid stations. The nurses conducted a maternity service and health conferences for mothers and babies. Caring for 15 492 patients, the staff made 143 589 home visits and gave 18 934 first aid treatments. The social programs also grew and included three kindergartens, as well as classes in carpentry, sewing, art, diction, music, and dance. Boys’ and girls’ clubs had a combined membership of 2500. In addition, the settlement staff oversaw men’s, young women’s, and mother’s clubs; a drama group with its own theater; two large scholarship funds; and numerous informal activities. In De-

ember 1912, attendance for all programs reached 28 000.¹⁵

While Wald was developing her new agenda for social and health reform, the changing emphasis of the “public health campaign” simultaneously created yet another aspect of the bond between nursing and public health. As the focus of the public health movement shifted from what eminent public health leader C.-E. A. Winslow described as the tasks of environmental sanitation and bacteriology to the personal conduct of the individual living machine, it required a new worker, a teacher of prevention. By 1910, most of the large visiting nurse associations and numerous boards of health and education had initiated preventive programs for schoolchildren, infants, mothers, and patients with tuberculosis. As the foot soldiers of a modern campaign for public health, trained nurses were being sent into the homes of the poor to teach healthful living and disease prevention. As one medical authority suggested, they were “the relay station to carry the power from the control stations of science, the hospital, and the university to the individual homes of the community.”¹⁶

American nurses saw health visiting as an opportunity for professional independence, status, and economic security, enabling the health visitor to provide what historian Susan Reverby called “care with autonomy.”¹⁷ By 1915, nurses entering this new field of public health also began to specialize, limiting their work to one age group or disease. Specialization, these nurses argued, allowed them to become experts, to lead others, and to contribute to the much needed literature—“able, in short, to do for the nursing profession what the specialist in medicine [was] so successfully doing for the medical profession.”¹⁸ By the 1920s, public health nurses were specializing in the care of those with venereal disease, tuberculosis, and mental illness, as well as in infant, child, and maternal welfare and in school and industrial nursing. Nevertheless, nurses who practiced in these specialty roles found it difficult to combine their educational functions with the “bodily needs” of patients. Many felt it unreasonable to expect that nurses would place health teaching above patients’ needs for a bath or treatment. Increasingly, the roles associated with care of the sick and health teaching diverged.¹⁹

Wald argued that the public health nurse was the link between families’ social, economic, and health needs and the services families required to become or



A public health nurse visits a migrant camp, 1920. Reprinted with permission of the Visiting Nurse Service of New York.

stay healthy. She was therefore opposed to specialization and to the distinctions between health teaching and direct patient care. If the message of health was to be carried to “troubled families,” something also had to be done *for* those families. Other approaches might be sincere but were rarely realistic; from Wald’s perspective, such an approach would be “cruelly sardonic on the part of the nurse.” Thus, the increasingly isolated and narrowly focused mission of health education challenged Wald’s vision of a broadly focused role for nursing in the struggle for social betterment. Specialization was antithetical to her concept of the public health nurse’s organic relationship to the neighborhood.²⁰

Nationwide Insurance Coverage for Home-Based Care

In 1909, Wald began her second experiment. Convinced that home nursing care could be a cost-effective investment for insurance companies, Wald proposed to the Metropolitan Life Insurance Company the testing of this proposition. Armed with data to document that nursing care saved lives, Wald urged Metropolitan Life to hire visiting nurses to care for policyholders during illness. For a modest fee per policy, Wald believed that Metropolitan Life could reduce the number of death benefits paid, and that without additional fund-raising by the settlement, services of the nurses could be

extended to more members of the working class. The insurance company agreed to test Wald’s proposal; it had nurses from Henry Street visit sick policyholders referred by their agents in one section of the city and compared the results with those involving similar policyholders in another section of the city. The experiment began in June 1909. After only 3 months, the results were convincing enough for the “wise directors” to authorize extension of the program to cover policyholders throughout the city.²¹

By 1911, “Mother Met,” as the company was affectionately called by the nurses, decided to offer nursing services throughout the entire country. At the cost of 5 cents per policy and 50 cents per visit, the services of the visiting nurses promised irresistible possibilities. There were, of course, obvious economic implications, but the potential for positive public relations created by such an enterprise certainly could not be ignored either. Where possible, Metropolitan Life arranged for existing visiting nurse associations to provide care, and where that was not possible, nurses were employed by the insurance company. It was indeed an arrangement of great mutual benefit to the insurance company and to the visiting nurse associations. Three years after initiation of the service, Metropolitan was paying for 1 million nursing visits each year at an annual cost of roughly \$500 000.²²



First visit to a typhoid patient. Reprinted with permission of the Visiting Nurse Service of New York.

Wald's vision, as articulated in this pragmatic social experiment carried out with Metropolitan Life, initiated more than 1 billion home visits nationwide for the insurance company between 1909 and 1952 and resulted in the establishment of the first national system of insurance coverage for home-based care. By 1914, the company asserted that in the preceding 3 years, its nursing services had contributed to a 12.8% decline in the mortality rates of policyholders. By 1916, the services of a visiting nurse were available to 90% of Metropolitan's 10.5 million policyholders in 2000 US and Canadian cities. By 1925, Metropolitan was claiming that 240 744 lives had been saved at an estimated savings of \$43 000 000 to the company.²³

For many years, as much as one third of the budgets for most visiting nurse associations came from Metropolitan Life. Here was a reliable source of funds not subject to the inevitable fluctuations in voluntary support. In addition, contracts with Metropolitan meant acceptance of patients without discrimination and the further extension of nursing services across the country, especially to the Black community of the South, where access to nursing care had been limited. Over a million Black policyholders could now receive the services of a visiting nurse when sick or pregnant.²⁴

Creation of a National Public Health Nursing Service

Wald's third experiment was the creation, in 1912, of the first national nursing

service in the United States. Her vast scheme for an American Red Cross Public Health Nursing Service promised nursing for people throughout the country. She proposed that the Red Cross "standardize" public health nursing in small towns and rural districts and coordinate the work of isolated nurses and nursing organizations under a central body. In Wald's estimation, it was a cause that "carried its own appeal." The Red Cross initially showed little interest, only sharing Wald's zeal when her sponsor Jacob Schiff and Mrs Whitelaw Reid offered to provide the money necessary to begin the nursing service.²⁵

Wald expected the Red Cross to develop policies and procedures for adoption by local chapters and to provide properly qualified, guided, and supervised nurses. Each chapter was expected to promote lay support and pay nurses' salaries. Thus, the Red Cross plan had national direction but local financing. Only the most highly qualified nurses would be employed, and their work would include bedside care of the sick as well as preventive services. At its peak during the 1920s, nearly 3000 Red Cross public health nursing services were active across the country.²⁶

Outcomes: 1920 to the Present

Wald's conceptualizations of the public health nurse, insurance coverage for home-based care, and a national public health nursing service were destined to become a nursing ideal rather than a sustainable reality. Reviewing the outcomes of

her three visionary experiments, however, does provide an opportunity to examine and interpret their relevance for our contemporary debate concerning health care reform.

Public Health Nursing

By the late 1920s, public health nurses had indeed demonstrated their ability to provide comprehensive health care to the American public, but the field had also reached a significant turning point. Despite the intent of a conceptually coherent and centrally structured set of public health services, there were nevertheless 4262 separate and independent local government and voluntary agencies sponsoring public health nurses. Growth had been tremendous during the previous decade, but most agencies were small undertakings, and more than two thirds employed only one nurse. Isolated and uncoordinated, they were increasingly vulnerable to shifts in community support and perceptions of need.²⁷

In many large American cities, such growth was characterized by an idiosyncratic mix of governmental and voluntary initiatives. With health departments, school nurse services, visiting nurse associations, and various other voluntary organizations providing an unpredictable assortment of both curative and preventive nursing services, the rationale for public health nursing became increasingly obscure to both its practitioners and the public. All organizations operated independently from each other with no single point of entry and no rational division of labor along geographic or other lines. Gaps and duplication of services were an inevitable outcome.²⁸

As the confusion grew, so did debate concerning the functions of voluntary, as opposed to, government agencies. A former health commissioner of New York City later recalled that "competition and rivalry in methods, resources, and accomplishments became as keen as selling soap or advertising toothpaste." Nor was the debate over the proper domain of public health practice confined to the struggles between voluntary and governmental organizations. Attempts by health departments to extend the focus of concern beyond sanitation, vital statistics, and health education resulted in conflict with the medical profession as well.²⁹

Predictably, most health departments were forced to abandon any claim to curative activities that might have been construed as a possible threat to the income of private physicians. Despite much

ongoing discussion, the emphasis of publicly supported services by health departments became increasingly preventive in nature. Health officers who favored this distinction concerning prevention believed that a nurse engaged in bedside care should not even be classified as a public health nurse. Direct care was considered therapeutic rather than hygienic because it dealt with individuals rather than with the maintenance of community health. Thus, an unexpected consequence of these debates and of the widening distinctions between services and the role of the nurse was use of public funding largely for the prevention of disease, with care of the sick left to voluntary agencies, especially visiting nurse associations.³⁰

In response to these changes, many nursing leaders began campaigning by the end of the 1920s for the creation of comprehensive, coordinated community-based nursing services. Separating curative and preventive functions of the public health nurse was now considered a mistake, and an argument was made for a combined model that would unite both voluntary and publicly funded agencies. Nurses within this more rational system would be general practitioners who would care for all people in the neighborhood, in sickness and in health, regardless of need or income. They would become what C. E. A. Winslow described as the "community mother," the trained and scientific good neighbor. Numerous studies and demonstration projects from the 1920s through the 1940s confirmed that duplication in administration, transportation, and services could be eliminated.³¹ But despite widespread support for this unification model and demonstration that it met the needs of most patients served by it, organized nursing was never able to create an institutional framework that would allow nurses to perform both preventive and curative activities.

At this point, nurses found few allies for the development of unified agencies because the social, medical, and demographic circumstances that had created the need for community mothers 20 years earlier were now much less urgent. Urban death rates were in sharp decline, and chronic degenerative diseases were replacing infections as the leading cause of death. Chronicity and disability did not have the fluctuating, dramatic, and often frightening impact that once led to civic concern and support for the work of public health nurses. As medical interest shifted away from problems of infection and public interest in the health of the poor de-

clined, the ongoing concerns of public health nurses became less and less widely shared.³² Simultaneously, medical, surgical, and even some obstetrical patients of all classes had begun to seek hospital-based care. The growing centrality of the hospital meant that fewer patients were sick at home or required skilled home care by a trained nurse.³³

In the absence of an influential or cohesive constituency, Wald's vision of nurses as guardians of the public's health could only partially be realized. Within both government and voluntary organizations, public health nurses found it increasingly difficult to create an institutional setting that would allow them to offer every kind of nursing service to their patients. Similarly, operating under the aegis of a variety of small, disparate, and dissimilar private and public agencies, public health nurses never generated the kind of organizational structures that might have permitted them to be a cohesive, recognized, and powerful group. It is little wonder, then, that the question "What is a public health nurse?" has been debated for more than 80 years.³⁴

National Insurance Coverage

The same dramatic changes that ultimately altered the role of the public health nurse also influenced the outcome of Metropolitan Life's nursing service. Services continued to grow until the depression, peaking in 1931 with 770 000 policyholders receiving care. The following year, however, nursing services began a substantial decline. From the perspective of the insurance company, the combination of cancelled policies during the depression and rising costs made visiting nurses seem a less economic method of preventing death. These compelling realities notwithstanding, the demise of Metropolitan Life's nursing service was predictable long before it actually happened. Changes in morbidity, mortality, and health care delivery had already occurred. Metropolitan's policyholders lived longer: their mortality rates had decreased by almost 50%, and they were increasingly more affluent and could purchase necessary care. Acute communicable diseases were no longer the major cause of death, and care of acutely ill and maternity patients was becoming the responsibility of hospitals. As a result, fewer policyholders needed or used the visiting nurse service; those seeking the services of a nurse were, most often, the elderly chronically ill. From an insurance perspective, nursing intervention in these cases rarely reduced

the death benefits paid by the company and was therefore considered a poor investment.³⁵

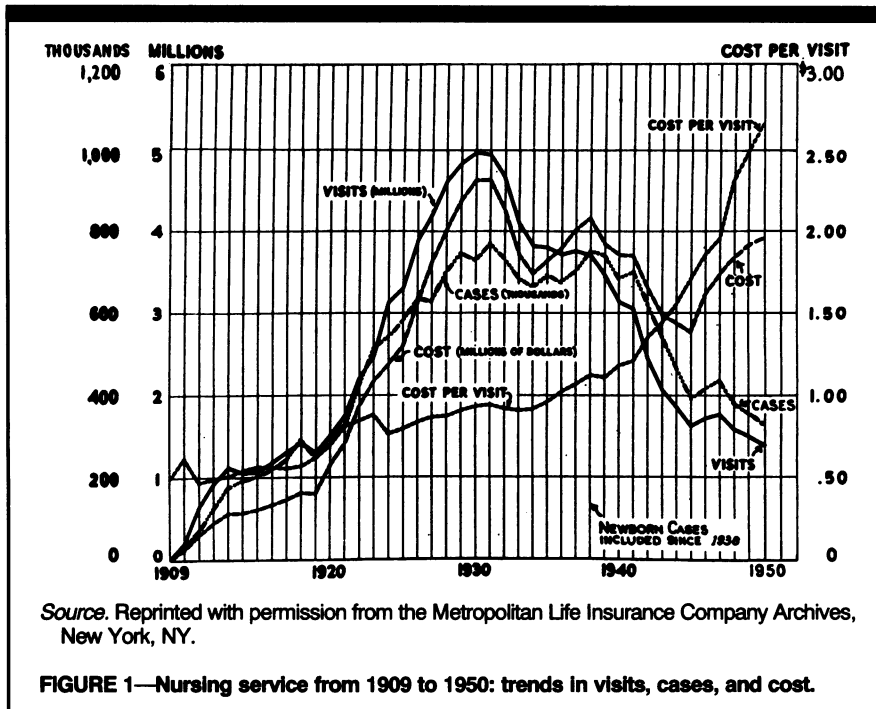
Metropolitan Life paid for 5 million nursing visits at a cost of about \$4.5 million in the 1930s; by their calculation, only 1.5 million visits in the late 1940s had cost nearly the same amount—about \$4 million. In addition, only 1% of the company's policyholders made use of the service. Thus, Metropolitan Life was spending \$4 million annually to care for 1% of the policyholders whose needs had little to do with the original mission of the nursing service. In 1952, with the number of visits to policyholders declining and the costs of services rapidly increasing, the company terminated its nursing program (see Figure 1).³⁶

National Nursing Service

The Red Cross story has an outcome not unlike Wald's two other experiments and dreams. Although delayed by World War I, Wald's "great movement" for the public's health was off to an enthusiastic beginning by 1919. Hundreds of local Red Cross chapters with a residue of funds from their war efforts, and a score of workers anxious to replace war duties with another great cause, had established Red Cross Public Health Nursing Services across the country. Controlling local chapter activities, however, soon proved extremely difficult. Insiders, who called the Red Cross the "greatest mother," would later admit these were alarming years when events proceeded almost out of control.³⁷

Hoping to establish some uniformity, at least in its staff, the Red Cross remained committed to hiring nurses with postgraduate training in public health. But demand for nurses quickly outran the supply. Beyond this obvious problem, sending young, inexperienced, city-bred and city-trained nurses to small towns and rural communities to adapt services harmoniously to local conditions was an arrangement destined for failure. According to Red Cross historian Portia Kernodle, a "kind of friendly feud" over standards and policies developed between some chapters and the distant national organization. The autocratic rulings of the Red Cross were increasingly unacceptable to these local chapters who wanted to run their nursing services in a manner suited to local conditions. They preferred to hire a nurse "they knew and liked" no matter what her training.³⁸

The Red Cross also failed to keep its commitment to provide the personal vis-



its, national correspondence, and defined standards that conveyed to isolated nurses a sense of support and encouragement. With shrinking budgets, the numbers of divisional offices and field personnel were reduced, and visits to local chapters were dramatically curtailed. With only an annual visit, nursing field representatives provided little guidance, support, or supervision. Predictably, in their absence other new programs began to compete with nursing for increasingly limited chapter funds.³⁹

The American Medical Association and The National Organization for Public Health Nursing, as well as local health departments and tuberculosis associations, questioned and even disapproved of the Red Cross's nursing enterprise. Critics claimed that the chapters initiated nursing services with insufficient funds or staff; with inadequate community support; and without cooperative agreements with existing agencies, health officers, or private practitioners.⁴⁰

By the latter part of 1921, the number of Red Cross nursing services in operation peaked at 1243, and support of local chapters began to waver as surplus funds from the war were depleted. During the 3 years between January 1921 and December 1923, Red Cross nursing services closed at an annual rate of 410 per year. By January 1924, only 804 services and 967 nurses remained. Although the rate of "withdrawal" lessened, the end was now in sight. In 1947, with only 100 Red Cross nursing

services in operation, the decision was made to discontinue the program.⁴¹

The Red Cross scheme for a national nursing service failed for a variety of reasons. This sweeping plan to give the Red Cross a peacetime mission and extend the work of the public health nurse across the country to small-town America was valued only by Wald and a few like-minded reformers. Sustaining interest in a national campaign for health in communities where commitment to locally defined free initiatives clashed with standards of the Red Cross was problematic—if not impossible. Assigning strangers to small towns where they only "trust the people they know" quickly caused difficulties and misunderstandings. Nurses, once again dispatched to do the impossible, were courageous and enthusiastic yet inevitably found themselves unemployed. But, most significantly, local chapters were unwilling to finance health services that ranked low in perceived importance to their immediate communities and constituencies.⁴²

Once again, the influence of multiple interest groups, an American commitment to pluralism, chronic resistance to centrally planned health care, and changing patterns of disease and health care delivery collided with Wald's agenda for the public's health. At the heart of it all was the quest for societal commitment to pay for community-based care, identification of those deemed to be worthy recipients of that care, and the public's apprehension

about the "dangerous sick, . . . the migratory microbe and the social malcontent."⁴³ Such statements, of course, reflect public sentiment concerning the social, economic, demographic, and health care issues of the times.

Historical Relevance for Contemporary Debates

Notwithstanding the problems associated with overreliance on lessons from the past, there are interesting parallels between our late 20th-century dilemmas and those confronted by Wald and her public health nursing colleagues 100 years ago. Then and now, frightening diseases, alienation among the disenfranchised, a vexing economic climate, and unmet health care needs of populations at great risk constitute a "crisis in caring."⁴⁴ However, nursing has demonstrated repeatedly its ability to provide simple, appropriate interventions for the vexing problems of vulnerable populations, especially when those problems are exacerbated by pressing economic and social forces. In this repetitious American scenario, how might we be guided by Wald's earlier experiments?

This is clearly a moment when what nurses can provide matches societal needs for community-based care. We must, this time, achieve a sustainable union between the two.⁴⁵ Historically, the most successful responses to both public sentiment and community need have depended on the ability of public health nurses to

1. invent a diverse mix of public and private programs that respect local custom, link effectively with mainstream health care institutions, and are substitutive, additive, or complementary to community needs;
2. counterbalance perceived costliness of community-based care by documenting cost-effectiveness, benefits valued by society, patient satisfaction, and/or responsiveness to sponsors' pluralistic agendas;
3. gain sufficient control over the structure and process of practice to produce the desired outcomes;
4. place practice within systems of reimbursement that provide payment appropriate to service costs;
5. articulate clearly the concept of comprehensive community-based nursing care, a concept that cuts across race and class and occurs at home, as an innovative and practical solution to the complex needs of vulnerable individuals and families;

6. produce practitioners with enough training and ability to manage all the complexities of community-based care;

7. couple preventive services with immediate health and social needs, rather than offering them in isolation; and

8. provide culturally relevant services according to local custom and linguistic preference.

One hundred years ago, Lillian Wald conceived of an alternative solution to the health care problems of her era. By simply putting herself into people's places, Wald recognized the need to conceptualize a new paradigm for nursing practice, one that addressed individual ills within a broader context of social concern. During the centennial year of public health nursing, we honor this noble past and reconsider its successes as a way to shape and guide the future of health care.⁴⁶ We can be reinvigorated by Wald's vision of the public health nurse: providing care from the patient's point of view; encouraging personal and public responsibility; and providing a unifying structure for the delivery of comprehensive, equally available health care. To reinvent that vision for the 21st century would be a fitting and lasting tribute to Wald and the thousands of other public health nurses. What an appropriate centennial celebration that would be! □

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- See Wald, *The House on Henry Street*, 3-24; Reznick, "The Years at Henry Street," 83; Daniels, *Always a Sister*, 70; and Duffus, *Neighbor and Crusader*, 35-40. These accounts do not totally agree.
- Duffus, *Neighbor and Crusader*, 34.
- For the quotation see Lavinia Dock, "The History of Public Health Nursing," *The Public Health Nurse* 14 (October 1922): 523. Duffus, *Neighbor and Crusader*, 34-40; Wald, *The House on Henry Street*, 1-14; Lillian Wald to W.R. Stewart, 10 October 1910, Wald Collection, roll 1; Lavinia Dock, "Whence the Term—Public Health Nurse?" *Public Health Nurse* 29 (December 1937): 712-714; Ellen Lagemann, *A Generation of Women: Education in the Lives of Progressive Reformers* (Cambridge, Mass: Harvard University Press, 1979), 68, 71-78; and Reznick, "The Years at Henry Street," 62-68.
- Nightingale and her associate, Mrs Dacre Craven, influenced Wald's thinking, as did Josephine Shaw Lowell, founder of the New York Charity Organization Society, whom Wald credited as her "guide." In Nightingale's idea of health visiting, which had been initiated in England, health visitors were missionary ladies with special training and practical instruction. The only significant variation in the American version of Nightingale's plan was to make the teacher of positive health the visiting nurse, not a lady missionary. See John S. Billings and Henry M. Hurd, *Hospitals, Dispensaries and Nursing: Papers and Discussion in the International Congress of Charities, Corrections, and Philanthropy, Section III, Chicago, June 12th to 17th, 1893* (Baltimore, Md: The Johns Hopkins Press, 1894), 444-463.
- Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (New York, NY: Oxford University Press, 1985), 245-296. For a discussion of gender and the development of public health nursing and settlement houses, see Barbara Melosh, "The Physician's Hand": *Work, Culture and Conflict in American Nursing* (Philadelphia, Pa: Temple University Press, 1982), and Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920* (Chicago, Ill: University of Chicago Press, 1985).
- The quotation is from Wald, *The House on Henry Street*, 8. Lillian Wald, "Treatment of Families in Which There Is Sickness," *American Journal of Nursing* 4 (December 1904): 427-431.
- For the quotation see Lillian Wald, "Nurses' Settlements," *The American Journal of Nursing* 1 (June 1901): 684. Lillian Wald, "Development of Public Health Nursing in the United States," *The Trained Nurse and Hospital Review* 80 (June 1928): 689-692; Lavinia Dock, "As One Nurse Sees It," *Charities and Commons* 16 (April 1906): 10-12.
- The quotation is from Wald, "Nurses' Settlements," 684. Wald, *The House on Henry Street*, 1-10, 26-28; Lillian Wald to Jacob Schiff and Mrs Solomon Loeb, 28 November 1893, 4 January 1894, and 4 March 1894, collection of the Visiting Nurse Service of New York.
- For the quotation see Wald, "Development of Public Health Nursing in the United States," 690. Wald discusses pricked consciences in Wald, "Nurses' Social Settlements," 683.
- Daniels, *Always a Sister*, 39-68. For an excellent review of this growth, see Reznick, "The Years at Henry Street," 161-189; "Report of the Henry Street Settlement, 1893-1918" (New York, NY: Henry Street Settlement, 1918); "Report of the Nurses' Department of Henry Street Settlement, 1909 and 1910."
- C.-E.A. Winslow, "The Untilled Fields of Public Health," *Science* 51 (9 January 1920): 23-33; Haven Emerson, "Meeting the Demand for Community Health Work," *Public Health Nurse* 16 (September 1924): 485-489. The quotation is from "Their Health Is Your Health," a fundraising booklet for the Henry Street Settlement, New York, 1934, 1. For a more extensive analysis of these developments, see Karen Buhler-Wilkerson, "Public Health Nursing: In Sickness or in Health?" *American Journal of Public Health* 75 (October 1985): 1155-1161.
- Susan Reverby, "A Caring Dilemma: Womanhood and Nursing in Historical Perspective," *Nursing Research* 38 (January/February 1987): 10.
- Lavinia Dock, "The History of Public Health Nursing," 525.
- Ira Wiles, "The Nurse of Tomorrow," *Public Health Nurse Quarterly* 7 (October 1915): 50; Harriet Leete, "Why Have Specialized Public Health Nurses?" *Public Health Nurse Quarterly* 8 (January 1916): 14-21; "Various Opinions on General and Specialized Nursing," *Public Health Nurse Quarterly* 8 (January 1916): 56-59; and Annie Brainard, "The Many Sided Opportunity of Field Nursing," *Public Health Nurse Quarterly* 8 (January 1916): 52-53.
- Wald expresses these views at the end of her career in the foreword to Marguerite Wales's book, *The Public Health Nurse in Action*, xi-xiv. The quotation is from Lillian Wald, "The Educational Value and Social Significance of the Trained Nurse in the Tuberculosis Campaign," *Transactions of the Sixth International Congress on Tuberculosis* 3 (1908): 637. In a letter to Adelaide Nutting, 13 May 1911, Nursing Archives, Teachers College, Columbia University, Wald mused that even if a family was visited by numerous nurses specializing in baby care, tuberculosis, maternity, contagion, or school health, the patient still might not be bathed or have a wound dressed.

21. Lillian Wald to Alma Haupt, 29 February 1937, Welfare Division, Nursing Service, Metropolitan Life Insurance Company Archives, New York, NY.
22. For a more extensive discussion of the Metropolitan Life Insurance Company's service, see Diane Hamilton, "The Cost of Caring: The Metropolitan Life Insurance Company's Visiting Nurse Service, 1909-1953," *Bulletin of the History of Medicine* 63 (Fall 1989): 414-434, and "Faith and Finance," *Image: Journal of Nursing Scholarship* 20 (Fall 1988): 124-127; Lillian Wald to Alma Haupt, 29 February 1937, Welfare Division, Nursing Bureau, Metropolitan Life Insurance Archives; Lee Frankel, "Insurance Companies and Public Health Activities" (Paper presented at the National Public Health Association, September 1913), 3, in the Frankel files, Metropolitan Life Insurance Archives; Alma Haupt, "The Metropolitan Story," *The Quarterly Bulletin for Metropolitan Nurses* 15 (November 1951): 4-24; Alma Haupt, "Forty Years of Teamwork in Public Health Nursing," *American Journal of Nursing* 53 (January 1953): 81-84; and Lee Frankel, "Life Insurance and Public Health" (Address delivered at the International Convention of Life Underwriters, 16 September 1926), in the Frankel files, Metropolitan Life Insurance Archives.
23. *Ibid.* The relationship between decline in mortality rates and nursing care is not verifiable and may be a function more of public relations than of causality. See Lee Frankel and Louis Dublin, "Visiting Nursing and Life Insurance," *American Statistical Association Journal* 16 (June 1918): 58-60, and "The Visiting Nurse Service: Conducted by the Metropolitan Life Insurance Company for the Benefit of Its Industrial Policyholders," Metropolitan Life Insurance Archives, 1917; Louis Dublin, "The Effect of Life Conservation on the Mortality of the Metropolitan Life Company: A Summary of Experience, Industrial Department, 1914, Superintendents, Medical Examiners and Visiting Nurses" (New York, NY: Metropolitan Life Insurance Archives, 1916). By 1952, when the service was closed, 1 075 000 000 home visits had been paid for by Metropolitan Life Insurance.
24. Karen Buhler-Wilkerson, "Caring in Its 'Proper Place': Race and Benevolence in Charleston, S.C.," *Nursing Research* 41 (Jan/Feb 1992): 14-20. Louis Dublin, "The Effect of Health Education on Negro Mortality," *Opportunity, Journal of Negro Life* 2 (August 1924): 232-234.
25. Collection of the American Red Cross National Headquarters, National Archives, Washington, DC; Lavinia Dock et al., *History of American Red Cross Nursing* (New York, NY: Macmillan, 1949), 1213-1215, 1220-1221; the quotation is from p 1214. Portia Kernodle, *The Red Cross Nurse in Action, 1882-1948* (New York, NY: Harper and Brothers, 1949), 71-72.
26. For statistics on the nursing service, see "Public Health Nursing, Changes in Service, July 1, 1919 to June 30, 1930," folder no. 140.18, American Red Cross collection.
27. Louise Tattershall, *Public Health Nursing in the United States: January 15, 1931* (New York, NY: National Organization for Public Health Nursing, 1931).
28. For a typical example of this pluralistic response, see Haven Emerson, *Philadelphia Hospital and Health Survey* (Philadelphia, Pa: Philadelphia Hospital and Health Survey Committee, 1930); Haven Emerson, "Meeting the Demand for Community Health Work," *Public Health Nurse* 16 (September 1924): 485-489; and Buhler-Wilkerson, "Public Health Nursing.
29. The quotation is from Emerson, "Meeting the Demand for Community Health Work," 488. For an example of this debate, see Francis Curtis, "Relative Functions of Health Agencies: Relationship between Official and Unofficial Agencies," *American Journal of Public Health* 10 (January 1920): 156-160.
30. Tattershall, *Public Health Nursing in the United States*; John Duffy, "The American Medical Profession and Public Health: From Support to Ambivalence," *Bulletin of the History of Medicine* 45 (1979): 1-22.
31. Typical of these studies and demonstrations are reports by Josephine Goldmark, *Nursing and Nursing Education in the United States* (New York, NY: Macmillan Co, 1923); *A Comparative Study of Generalized and Specialized Health Services* (New York, NY: East Harlem Nursing and Health Services, 1926); "East Harlem Service Discontinued," *American Journal of Nursing* 41 (May 1941): 299; and the National Organization for Public Health Nursing, *Survey of Public Health Nursing: Administration and Practice* (New York, NY: Commonwealth Fund, 1934). C.-E.A. Winslow used the term "community mother" in his 1917 speech, "The New Profession of Public Health Nursing and Its Educational Needs," 4, Winslow Collection, folder 119: 128, Yale University Library.
32. Leavitt and Numbers, "Sickness and Health in America."
33. Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York, NY: Basic Books, 1987), and Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York, NY: Basic Books, 1989).
34. For example, see Mabelle S. Welsh, "What Is a Public Health Nurse?" *American Journal of Nursing* 36 (May 1936): 452-456. This question is still being debated. See also what is considered to be the classic article within this contemporary debate: Carolyn Williams, "Community Health Nursing—What Is It?" *Nursing Outlook* 25 (April 1977): 250-254. And see "The Definition and Role of Public Health Nursing in the Delivery of Health Care," position paper no. 8132, American Public Health Association Public Policy Statements, 1948 to present, cumulative, current volume, Washington, DC.
35. "1909-1952, The Metropolitan Nursing Service" (termination announced July 1950; effective 1 January 1953), memo, Welfare Division, Nursing Service, Metropolitan Life Insurance Archives. See also "Mission Accomplished," *The Quarterly Bulletin for Metropolitan Nurses* 15 (November 1951), as the complete issue reviews the history of the service and related cost, visit, and case data; "A Report of the Study of the Effect of the Termination of Metropolitan Nursing Contracts," *Public Health Nurse* 43 (May 1951): 285-293; and Haupt, "Forty Years of Teamwork."
36. *Ibid.* for entire reference. These cost figures are not adjusted.
37. For a more detailed discussion, see Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930* (New York, NY: Garland Publishing, 1990), 221-228, and "Guarded by Standards and Directed by Strangers: Charleston, South Carolina's Response to a National Health Care Agenda, 1920-1930," *Nursing History Review* 1 (1993): 139-154. See also Dock, *History of American Red Cross Nursing*, 1293-1351, and Kernodle, 256-286. Elizabeth Fox, who was for many years Director of the Red Cross Public Health Nursing Service, referred to the "mother" role in her monthly report, 3 June 1929, folder no. 140.18, PHN, ARC, NA.
38. Kernodle, *The Red Cross Nurse in Action*, 278-281. For Red Cross instructions to chapters, see "The Organization of a Public Health Nursing Service," 1 March 1919, Form A 701, folder no. 151, PHN, ARA, NA; "The Organization and Administration of a Public Health Nursing Service," folder no. 151; and "Report of Public Health Nursing Service, July 1, 1920 to June 30, 1921," folder no. 140.18, PHN, ARC, NA.
39. Dock, *History of American Red Cross Nursing*, 1267-1268, and Kernodle, *The Red Cross Nurse in Action*, 267-268, 272, 281-282.
40. Kernodle, *The Red Cross Nurse in Action*, 275-278; Buhler-Wilkerson, *False Dawn*, 221-228.
41. Kernodle, *The Red Cross Nurse in Action*, 263, 281-283, 300-305, 362-364, 408-418, 467-473; "Public Health Nursing, Changes in Service," American Red Cross collection.
42. Buhler-Wilkerson, "Guarded by Standards."
43. "Their Health Is Your Health," a fund-raising brochure used by the Visiting Nurse Service of New York, 1934, 6.
44. For an excellent discussion of this crisis in caring, see *Connecting: Challenges in Health and Human Services in Philadelphia* (Philadelphia, Pa: Pew Charitable Trusts, 1989).
45. For the contemporary basis for these criteria, see Susan K. Riesch, "A Primary Care Initiative: Nurse Managed Centers," in *Nurses, Nurse Practitioners*, ed. Mathy Mezey and Diane McGivern (Boston, Mass: Little Brown and Co, 1986), 242-248; Lisbeth B. Schorr with Daniel Schorr, *Within Our Reach: Breaking the Cycle of Disadvantage* (New York, NY: Doubleday, 1989); and the US General Accounting Office, *Home Visiting: A Promising Early Intervention Strategy for At-Risk Families*, GAO/HRD-90-83 (Washington, DC: July 1990).
46. Wald, *The House on Henry Street*, 26-27.