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From Function to Competency in Public Health Nursing, 1931 to 2003

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Abstract Explaining the content of public health nursing practice is not a new phenomenon. This historical narrative examines two documents published in the first *Public Health Nursing* journal, in which the National Organization for Public Health Nursing (NOPHN) described the nature of public health nursing for the profession and for those who administered programs employing public health nurses. While changes in language reflect evolution of both the nursing profession and public health practice, consistencies in purpose and the core understanding of public health nursing link these documents conceptually to the recent statement of Public Health Nurse Competencies (Quad Council, 2003).

Key words: competencies, function, history, public health nursing.

Like other nascent professions in the early 20th century, public health nursing was eager to explain to other professions and to the public its unique contribution within nursing. Although the title public health nurse was already in limited use, Mary Gardner (1912) reported that during the effort to create a national organization, the favored name was the National Visiting Nurse Association. Two of the founding members, however, held out for what they considered a more inclusive title, the National Organization for Public Health Nursing (NOPHN). Visiting nursing did not mean the same thing in all parts of the country, they contended, while public health nursing encompassed visiting nurse work whether or not it involved bedside care of the sick, school, factory, welfare, tuberculosis care, and social service, as well as emerging areas of public health concern. Apparently, the argument was persuasive. The new organization used public health nursing nomenclature, but with that came the perceived necessity of defining the term "public health nurse" and describing what the public health nurse did.

The NOPHN assumed this task and set the stage for the development of functions and abilities, what we now describe as competencies. By 1929, public health nursing was defined as

> …an organized community service rendered by graduate nurses to the individual, family, and community. This service includes the interpretation and application of medical, sanitary and social procedures for the correction of defects, prevention of disease and the promotion of health, and may include skilled care of the sick in their homes. (NOPHN, 1929, as cited in "The objectives in public health nursing," 1931; p. 439).

Mere definition, however, did not suffice as a guide to practice, to the education of public health nurses, to administrators and health officers employing public health nurses, nor for the lay person trying to decide whether a public health nurse was needed. In 1931, general and specialized objectives were developed by the Field Studies Committee of the NOPHN. General objectives included education of individuals and families for protection of health, assistance in adjustment of conditions that affect health, correlation of health and social programs for the welfare of both family and community, and community education for the development of public health facilities (The objectives in public health nursing, 1931; p. 439). In contemporary parlance, the public health nurse was to educate, change social and environmental conditions, coordinate professional efforts, and develop community resources for the benefit of individuals and families.

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Eighteen years later, Pearl McIver (1949), chair of the Subcommittee on Functions (of the public health nurse), would characterize the 1931 document as the first comprehensive statement about the nature and scope of public health nursing. It identified 12 functions ascribed to generalized public health nursing and elaborated objectives to be met by public health nurses within each function. Examination of both the functional categories and the objectives is instructive. The 12 functions were maternity, infancy, preschool, school, and adult health services; morbidity, communicable diseases, tuberculosis, syphilis and gonorrhea; orthopedic; industrial; and mental hygiene. McIver (1949; p. 65) commented, "A person unfamiliar with the philosophy of considering the family as a unit would naturally conclude that each service was carried by a special nurse or a separate group of nurses." The objectives tell us what nurses were expected to be able to do within each function of public health nursing. For example, in maternity service, the objectives included early contact with pregnant mothers, assurance that both medical and nursing supervision were provided throughout the maternity cycle, instruction of mothers and fathers in maternal hygiene and infant care, instruction in preparation for delivery, arrangement or provision of nursing care during delivery and postpartum, and securing of a postpartum physical examination for the mother and a pediatric examination for the newborn (The objectives in public health nursing, 1931; p. 439). Disease-oriented functions such as syphilis and gonorrhea included objectives related to finding of new cases, following contacts, providing on-going treatment or assisting in the medical treatment of the disease, assistance in securing complete reporting, and instruction of individuals in personal hygiene (p. 441).

Revisions made in 1936 and in 1944 continued to delineate functions by disease or age categories and both included function-specific objectives (McIver, 1949). McIver ruefully noted that a vast majority of the functions began with the verbs "assist" or "help." The net effect, opined McIver, was that "some professional groups have wondered if public health nurses have a professional content of their own, or if they are employed to be 'the handmaiden of the doctor,' and are incapable of taking any independent action!" (p. 65).

The post-World War II era brought new expectations and challenges. Economic hardships imposed by the Great Depression had left community-based services such as visiting nurse associations in a changed and precarious position. In the midst of the Depression, the NOPHN had undertaken a study with Commonwealth Fund support that showed the disarray of services—isolation from systems of care, duplications and gaps in service, and geographic variations in coverage (Buhler-Wilkerson, 2001; p. 179). Many city and county health departments were unwilling to provide in-home care, and by the early 1940s, the war had created shortages of nurses and physicians. Rather than address the need for a comprehensive system of care, leaders of the profession attacked the problem of changing demands and inadequate resources once again by examining the role and function of public health nurses. In 1947, discussion among the nurse executives of visiting nurse and public health agencies took on an urgent tone. They wondered whether, with the proliferation of other professionals, the function of the public health nurse ought not be redefined (Public Health Nursing Executives Talk It Over, 1947). The group believed, however, that the functions remained the same, but that the education of nurses and the application of skills required reevaluation. The NOPHN Committee on Nursing Administration charged its Subcommittee on Functions with formulating a new statement about the nature of public health nursing that would be useful to administrators, appropriating bodies, and boards of directors (McIver, 1949). Federal funding expanded local public health initiatives in the postwar period; hence, the statement is particularly geared to an audience responsible for implementing and overseeing initiatives in community health.

The change in language from public health to community health was significant. Community health supposedly reversed the "restrictive" concept of public health. Earlier public health efforts were now perceived as having been focused on control of environments through sanitation and control of communicable diseases through isolation and eradication (Subcommittee on Functions, 1949; p. 67). Public health was understood as population-based, that is, less invested in education and change of individual behaviors. Community health, on the other hand, emphasized the dissemination of medical benefits and scientific advances of the postwar period. Interventions in the community health paradigm involved (1) care and rehabilitation of the sick and disabled, (2) promotion of healthful living, and (3) prevention and control of disease (Subcommittee on Functions, 1949). Public health nurses had always been employed to care for the sick and to work in specific control programs that were disease-focused, but nurses had demonstrated how effective their services could be if, while they were there treating the sick and enforcing public health controls, they also provided for all of the services that a family unit needed (Subcommittee on Functions). Furthermore, times had changed and nurses were no longer willing to be the "field workers" in systems that, however nobly stated their missions, served as agents of social control. The Subcommittee

noted that because lay people were more knowledgeable in matters pertaining to health, nursing personnel needed to be more comprehensively educated. Presumably, public health nurses with broader vision and a higher degree of education would present information and advise the public rather than simply implement policies over which they had little control. Although without elaboration in the Subcommittee's preface, it is useful to note that the role of the patient had seemingly changed, as well.

The new statement, "Public Health Nursing Responsibilities in a Community Health Program," (Subcommittee on Functions, 1949) outlined three main areas of action, in which nurses, allied health professionals, and community groups would collaborate. The first was nursing care and health guidance for individuals and families across settings, including home, school, work, hospitals, and clinics. The second set of responsibilities involved collaboration with other professionals and citizen groups in the study, planning, and operationalization of community health programs. The third and final area of responsibility lay in education for nurses, allied health professions, and community groups.

Reconceptualizing the scope of public health nursing practice in this way forced the Subcommittee to look specifically at what nurses could contribute to a collaborative enterprise. With this iteration, the nurse stopped being the agent of a supervising professional such as a physician or health officer. Instead, the 1949 statement attributed to public health nurses an independent and highly skilled role in community health. Examination of selected responsibilities illustrates the transformation from helper to colleague. In the area of individual and family care, the first of the three classifications, nurses were said to be responsible for providing part-time care to patients while educating family members, guiding families to recognize their needs, and counseling them in those areas of need. The nurse was to interpret medical information and teach individuals and communities to manage complex medical regimens, guide individuals with social and emotional problems, make referrals, perform diagnostic testing, and interpret findings for families. Last in this category, nurses were responsible for working with families to ensure that their environments were safe and healthful. Although nurses had done all of these tasks with family units for many years before 1949, the responsibilities are stated in substantively different ways, reflecting a move away from the assistive model toward autonomous practice. Guidance, teaching, interpretation, and social and environmental management were viewed, at least by NOPHN leadership, as within the independent purview of postwar public health nurses.

Nurses' responsibilities in planning for community health programs also reflected an expanded role. No longer was case finding simply a question of neighborhood networking; now, the public health nurse was responsible for taking part in epidemiological studies, field investigations, and examination of selected population groups. She was expected to be sufficiently skilled in data analysis to interpret records and statistics pertinent to the development of programs. Managerial or, at minimum, supervisory skills were required to formulate and evaluate organizational nursing programs with emphasis on coordination of services and economical use of personnel and resources. The public health nurse was responsible for budgeting and staffing for community-wide efforts. Nurses were also to participate in planning, not only for nursing services, but for the "eradication of social and economic conditions known to contribute to poor health" (Subcommittee on Functions, 1949; p. 69). Nursing care in hospitals, clinics, schools, industries, and homes needed comprehensive planning that involved work with community planners. Public health nurses were expected to work with residents of communities to increase citizen participation in developing public health programs. Lastly, under this category, nurses were as responsible for public information and public relations as their professional counterparts.

The educational component of the public health nurse's responsibilities illustrates how far the nursing profession had matured. Many working public health nurses of the era had been educated in hospital training programs and received post-diploma education in public health nursing at universities. In the 1949 document, the Subcommittee recognized educational responsibilities that extended into the community as well as into formal academic institutions where post-war nurses were increasingly prepared. Public health nurses were expected to be able to plan, conduct, and evaluate in-service education not only for nurses but for other health personnel in schools, hospitals, and social welfare organizations, and to instruct community groups in basic nursing care for maternity and family nursing care. As a group, public health nurses were charged to cooperate with schools and universities to prepare faculty and aid in the education and promotion of public health nurses. Individual nurses were expected to participate in field practice, that is, to serve as what we now call preceptors and clinical educators, to assist in the education of allied health professionals, and to educate high school and college career counselors, school administrators, and students about opportunities in public health nursing.

The 1949 definition of public health nursing functions extended well beyond the functions articulated in the 1931, 1936, or 1941 versions. It also mirrored a transformation

in the environment. Medicine, hospitals, public health, nursing, and social welfare agencies had all had to redefine their respective roles in an era when communicable diseases seemed to be under better control, chronic illnesses were recognized as an increasingly troublesome burden, and economic and social pressures presented new care opportunities and dilemmas. The disease- and age-specific models gradually came to be perceived as outdated approaches to public health issues. The Subcommittee's position in 1949 reflected a more comprehensive approach to the levels at which change takes place. It also harbingered a pragmatism about survival in an increasingly competitive environment. An apologist for the document, Clarissa Gibson (1951), executive director of the Visiting Nurse Association of Scranton and Lackawanna Counties of Pennsylvania, called "Public Health Nursing Responsibilities" a "blueprint," and she emphasized the need to act in conjunction with the members of a multidisciplinary team to achieve goals. Her ideal of "creative" nursing included currency of knowledge, ability to see the whole picture, and acceptance of responsibility for advocacy for individuals and communities. As a model, the 1949 document was believed to be more pliable in the face of changing content demands—a better fit for a more modern world.

Whether the documents produced by committees of the NOPHN were designed to be vision statements or whether they should be viewed as reflections of current practice can be determined in a number of ways that exceed the scope of this article. There is evidence to suggest that for both the 1931 and the 1949 documents, reflections of evolving practice is the most accurate descriptor. Even when recounting the state of the art, official documentation of core purposes, functions, and abilities enables practitioners to articulate more effectively to others what public health nursing is.

The publication of the PHN Competencies (Quad Council, 2003), published in this issue of *Public Health Nursing* represents the newest iteration of public health nursing roles and capabilities. To be used in conjunction with other contemporary definitions and standards, we know from the prologue that the document is a deliberate effort to articulate the linkages between practice requirements and abilities as acquired through education, applied specifically to public health nursing. In this, it is not substantively different in purpose from previous efforts to articulate the fine detail of what we do. Both historical function statements and the current competencies illustrate that public health nursing is something *more* than either population-based or individually focused, just as it was more than performing disease-specific or age-specific interventions. Public health nursing, as defined by nurses for nurses, has always melded understanding of the conditions that shape health at the global, national, or community level, and detailed attention to the individuals who require care at the personal level. Although, as the Quad Council observes, public health nursing remains population-focused, "… one of the unique contributions of public health nurses is to apply these principles *at the individual and family level* within the context of population-focused practice" (emphasis changed) (Quad Council, 2003).

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