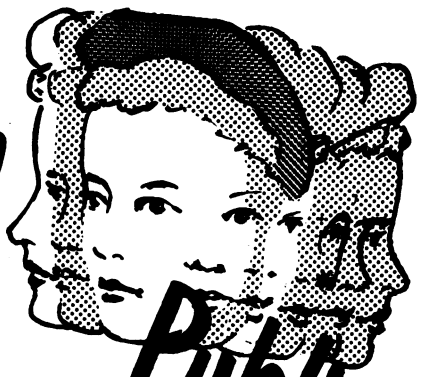
# Priorities in Public Health Nursing



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THE PROGRAM of the health department seems more complex today than ever before, though a study of history might reveal that this is not a phenomenon of our age alone but a normal attribute of a changing, growing service, a situation to be welcomed rather than deplored. Indeed we would welcome new demands for services, new heights to conquer, if we only had enough staff to send up to each new mountain top. Shortage of people in the "service" occupations exists, however, and there is every prospect that it will continue to exist in the foreseeable future. We must therefore plan to use the available staffs wisely, wisely both in terms of the community's needs and the staff's ability to meet those needs. Health workers, like all other people, need a feeling of satisfaction in a job well done; they should not perpetually feel frustrated by their inability to do all that they see needs to be done. This requires building priorities into our program plans.

The whole subject of deciding on priorities and acting on our decision has wide ramifications into all aspects of our lives. The differences in certain philosophies and religions is primarily a difference in what has priority. Psychiatry regards a person's inability to make a decision as a definite sign of mental illness. This indecisiveness is, in other words, the inability to give priority to one activity over another at any given instant. The person who suffers from this extreme of indecision often has to be hospitalized. But I wonder whether there are many of us at large who do not suffer from some degree of the same complaint. Be-

*The paper is based on a talk given by Miss Arnstein at the June 1957 meeting of the New York State Public Health Conference, while she was chief of the Division of Nursing Resources, Public Health Service. Miss Arnstein is now the Service's chief of Public Health Nursing Services.*

cause of it we say we are run ragged or exhausted by all the things we have been doing. How many of us have said at one time or another, "My workload is impossible!" "I can't do everything."

If I were a cartoonist I think I might draw the public health nurse as a beast of burden surrounded by people loading packages on her back, and more people in the distance coming with more packages. The labels on the packages are so familiar that I am not going to list all of them. We would see maternal and child health, tuberculosis, and school programs already securely tied in place, and heart, diabetes, and many others being added to the load. The caption on the cartoon would be "The public health nurse as she sees herself." In order to rescue this burdened, willing worker, we must decide what size load she can carry and then choose which bundles should go on her back on the first trip, and which on subsequent ones.

In this article, I would like to discuss the process of choosing which activities should have priority rather than discussing the activities themselves and trying to put them in rank order. Putting activities in order of rank carries the implication for me that there are times when some at the bottom of the list may not be reached.

### The Selection Process

First we must consider what is involved in deciding which activity should have priority; then we must act on our decisions; and finally, we must feel satisfied with our actions—that is, we must not have guilty feelings that we have neglected something we should have done. Because each of these steps is progressively more difficult, most of us use escape hatches to save ourselves in the hope that somebody else will take the helm and spare us the trouble of plotting a course through the channel. One escape hatch is blaming someone else—the health officer, for instance, or the specialized consultant; in private life, our families or even our friends. Another is unwillingness to admit that there can be any priority: everything is of equal importance and must be done. The last method of dodging the priorities issue often comes to the fore if one tries to help a friend or co-worker cut down on his workload.

Let us review the steps we go through sometimes unconsciously when we decide on priorities.

First, we must have knowledge: knowledge of the need for the activity; knowledge of what each action entails, why it is done, what the probable results will be if it is carried out, and what will happen if it is not; knowledge as to whether we are the only ones, or the proper ones to do it.

Second, we must have analysis: that is, seeing the separate facts we have gathered as a whole and in relationship to each other.

Third, we must have acceptance of the conclusions reached in the analysis. We have to believe emotionally as well as intellectually that the decisions are right. This is particularly difficult if someone else did the analysis, for example, if the health officer, or someone in the State health department passes on the results of his analyses to the local nurse who has to carry them out.

Fourth, we must feel as competent to carry out the programs given top priority as those given low priority. This is a crucial requirement when a major change in priorities occurs. If we don't feel equally competent in both areas we have to take steps to become so. If all these steps have been taken then the ultimate goal—action—will result.

Finally, we have to feel satisfied with the activities performed according to the priorities decided upon, and satisfied with those not performed because time did not allow us to get that far down the list. This feeling of satisfaction depends not only on our acceptance of the decisions we have made, but also on our own personalities.

Everyone has a need to be loved and some people need constant reaffirmation that they are loved. For many, this means that they are approved, that all their actions are approved by everyone, that they live up to the ideal they have set for themselves, and that they think others have set for them. We call these people perfectionists. Obviously when we use these terms to describe a perfectionist his goals become ridiculous. No one can please everyone all the time. In terms of the subject of this

article, no matter which actions we give priority to there will be some who think our analysis was wrong, or our judgment was poor, or if we had just applied ourselves more diligently we could have completed the whole list. As nurses we are particularly sensitive to this type of criticism. We—the majority of us—entered nursing to help people. All the studies to date have shown this to be the outstanding motivation. Society thinks of us as helping people and a helping person should help. She should not say "no" or suggest that someone else can do the service needed.

An example from our out-of-office lives illustrates these steps though we are not, as I said, usually conscious of going through them. The following activities have been proposed for a Saturday by someone, ourselves or others: (*a*) pay bills; (*b*) clean the house; (*c*) go swimming; (*d*) write a paper for *Nursing Outlook*. (There would be other activities on the normal Saturday list but this will do for purpose of illustration.)

What are the facts? That is, what is the need for the action, and what are the results if the activities are done or left undone?

**pay bills?**

*Facts:* There are 8 bills to be paid, received almost 1 month ago. Our credit rating is now A.

*Results:* If the bills are paid, credit rating stays high; if not paid, credit rating might drop but this is unlikely on the basis of 1 month's lapse.

**clean the house?**

*Facts:* It is dusty, the wastepaper baskets are half-full, it is in disorder. We have a rule that the house should be cleaned at least once a week.

*Results:* If the house is cleaned, dust and dirt will not be ground into fabrics and they will last longer; our aesthetic senses will be gratified. If the house is not cleaned, some day in the future we will have to replace the fabrics X number of years sooner; we will have less pleasure in looking at the house; the wastepaper may overflow, which is a nuisance.

**go swimming?**

*Facts:* This is a healthful exercise. The weather is hot. We have just read an article by Dr. Paul Dudley White—who is an authority—that exercise is important in maintaining health.

*Results:* If we swim we will feel fine, refreshed, and enjoy ourselves, but we may feel guilty or stay up half the night doing the other things on the list. If we don't swim, we will not get refreshed, may not do other things well, will resent our decision (or when younger, our mother's decision).

**write the paper?**

*Facts:* We promised the paper by July 1. Only 1 week is left; we have 1 free half day in the office next week.

*Results:* If the paper is completed, we will have great sense of accomplishment, appreciation from editors for promptness; when the paper is printed, our ideas will have an influence on others and also get recognition from co-workers. If we don't write the paper, we can do some of it in the office, can get it in late and be criticized by the editors, or can risk later publication.

Then comes the complicated analysis of the relationships of all of these facts to each other, and judgment enters in because there are no statistical measures. There is no one index marked "Satisfactory Saturday."

This is the action which might be taken on the basis of the analysis of the facts. We decide to empty the wastepaper baskets but let the rest of the house cleaning go. The facts about the relationship of dirt to length of life of the material are not clearly proved; many other factors enter in. Aesthetics are not so important as we will either be swimming or writing the paper or paying bills. We decide we can pay some bills, then we will have time to pay the rest next week. We will swim, and start the paper in the office and finish it next weekend if necessary.

We can follow this same process in making a home visit. We are all familiar with the admonition to start our health supervision visits with the family's interest, meet their needs first. We have a harder time when it comes to teaching them the procedures we learned in our

schools of nursing. There are no priorities here; every step is equally important, or at least that is the way we often were taught.

It is not easy to decide which single thing one would teach a family if only one thing could be absorbed by them. It is a very good exercise to think about priorities in this way. After deciding what should come first, think what should be taught second if only two things can be taught, and so on.

For example, the public health nurse visits a household where she finds this situation: Mike, age 12, has a streptococcal sore throat. John, age 10, has previously had rheumatic fever. The boys sleep in the same room. In her background of knowledge, the nurse has specific facts about rheumatic fever and streptococcal infections. She analyzes these and forms a judgment. Priority 1 is to keep the boys apart. Priority 2 is to keep John taking prophylactic penicillin. By the time she has helped the family work out alternate sleeping arrangements for John, various ways of making sure he doesn't go into the room to play or to get something, the family's time and concentration powers have run out. So she does not teach anything further in this visit about the isolation technique, she says nothing about boiling dishes and burning paper handkerchiefs, for she has decided these have lower priority at this time. Nor does she mention anything regarding diet and care for Mike. Obviously we could go into much greater detail and discuss why she chose these priorities and whether or not we can agree with her. But stated in brief, this case is just one illustration of the omissions which must occur at times when one plays the priority game seriously.

This analysis of what is most essential in any given situation or procedure and why it is priority 1, 2, or 10 could be an important part of our teaching in the basic professional schools of nursing. It would help sharpen our thinking to consider why we do the things we do and their relative importance under varying conditions.

### The Community Program

When we apply these steps in planning a public health program for the community, we again get the facts first. We are on familiar ground in this first step. We know we must find out what the most important health problems of a community are before we develop a specific plan of action. We are accustomed to looking at mortality data and morbidity data when the latter is available. Today in most communities in this country we would find diseases of the cardiovascular system at the top of the list, with cancer and accidental deaths among the top five. Maternal and infant mortality would be at the bottom along with deaths from the acute communicable diseases. This is one set of facts about needs of the community, but there are others which may be in conflict just as there were in the activities for a Saturday in summer which I mentioned earlier.

There are facts about the interests and demands of various groups in the community. The school principals want a health program for the school children. The physicians want nurses to give injections in the homes—to their patients with anemia, allergies, or infections. The parents want poliomyelitis "shots" for their children and perhaps themselves.

The special consultants from the State health department are each pressing us to put our efforts into such different programs as positive health guidance for mothers and children, care of the posthospitalized tuberculosis patient, care of the posthospitalized mental patient, heart disease and cancer control programs, supervision of the health of the aged, especially in nursing homes, reemphasis on immunization against diphtheria and smallpox.

There is another set of facts we gather, and that is information about the community resources available to meet some of the needs revealed by the facts already listed. We are not alone; we need not try to do the whole job ourselves.

We find the Junior Chamber of Commerce has started a hospital program of recreation for older citizens; the tuberculosis and public health association used to be very active but has not done much recently; the local heart association has just been organized; the Junior League is working in the hospital outpatient department; there are a number of inactive nurses living in the community.

Although the above listing presents a com-

plicated picture, it is not nearly as complex as a real community would be. Obviously the analysis of these facts and their relationship to each other in order to arrive at priorities in our program will require time, thought, and judgment. When all factors had been taken into consideration we would probably find that no program activity would be completely ruled out. We would do part of each, giving more time—more priority—to some than to others just as we did when planning our Saturday's activities.

Our priority plan would help us in meeting pressures for more of any given service. If it had a low priority, the group exerting the pressure would have to show why this service should be moved higher in the list, thus automatically depressing other services.

This does not mean that the plan made at the beginning of the year, the beginning of the week, or even the day's plans can always be followed. In health work there are always emergencies; there are always unexpected demands. It may be poliomyelitis vaccination clinics, or an influenza epidemic, or a special study of new drugs for home treatment of some disease which claims our attention. These may have to take priority for short periods over all other activities in our program plan. When this happens the decision has often been made by someone else, but if we understand the reason for the decision we can accept it and give it first consideration in our own minds.

In summary, in order to establish priorities we first must have knowledge based on facts and experience; we must make an analysis of the relationships of the various facts; then, because there are no mathematical formulas to show us which activity should have priority, we must use judgment in the interpretation of our analysis. The action we take, the program we carry out, is the result of the above procedures. We can then go home—if we have dealt with our personal need to please everyone—at the end of each day, at the end of each year, satisfied that, according to our best knowledge and judgment, what has been left undone was less important than what has been done.

## U. S. Injury Estimates, July–December 1957

During the last half of 1957 about 25 million Americans were injured seriously enough to require medical attention or to limit their activities for at least a day, according to a preliminary report by the Public Health Service's U. S. National Health Survey.

Injuries during this period resulted in almost 214 million days of restricted activity, including 55.5 million days spent in bed at home or in a hospital. The report also shows:

- Home accidents injured 10,065,000 people, or 40.3 percent of all injured.
- Work accidents injured 4,173,000, or 16.7 percent.
- Motor vehicle accidents injured 2,444,000, or 9.8 percent.
- Other kinds of accidents and injuries resulting from violence involved 8,267,000, or 33.1 percent.
- Of the total injured, 14.1 million were males and 10.8 million, females; 14.9 million were urban residents; 7.1 million lived in rural nonfarm areas; and 3 million lived on farms.

The Preliminary Report on Number of Persons Injured, United States, July–December 1957 is the third in a series based on continuing nationwide household interviews, conducted for the Public Health Service by the U. S. Bureau of the Census.