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Nurses' occupational health as a driver for curriculum change emphasising health promotion: An historical research study

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SUMMARY

Background: Reasons stated for curriculum change in nursing education are usually shifts in knowledge, care delivery, roles, regulatory standards and population health needs. In New Zealand in the 1930s, a curriculum change was driven instead by the need to protect and promote nurses' health. Tuberculosis was an international occupational health risk among nurses. Mary Lambie, New Zealand's chief nurse, considered nursing a "hazardous profession". One remedy she instituted was curriculum change in the national nurse training programme to emphasise health promotion among nurses. Global nursing issues today also impact on nurses' health. Curriculum changes again address this by promoting self-care and resilience.

Objective: To examine how international and national concern for nurses' occupational health drove a curriculum change in New Zealand nurse training in the 1930s.

Design: Historical Research

Methods: International occupational health reports (1930s), Lambie's annual reports (1932–1950), and questions and examiners' comments in a new state examination (1940s–1950s), were analysed to identify the reasons for and direction of the curriculum change. Findings were interpreted within international and national concerns and measures related to occupational health in nursing.

Results: Lambie used the political leverage of international and national worry over tuberculosis as a nursing occupational health risk to protect nurses' health more generally. In 1933 she revised the first year of the three-year national nursing curriculum to emphasise personal hygiene and bacteriology related to cross-infection, and in 1938 introduced a State Preliminary Examination at the end of the first year of training to test this knowledge. Analysis of examinations, 1940s–1950s, confirms that the curriculum change driver was a concern to make nursing a less "hazardous profession".

Conclusion: Nurse educators today should be aware of the variety of factors that can lead to curriculum change in nursing. In addition, concern for nurses' health today demonstrates the continuing need for health promotion in nursing curricula.

Introduction

The reasons given for the continual curriculum change in nursing education are changes in knowledge and care delivery, nursing role development, alterations in regulatory bodies' professional standards, and the shifting health needs in the population the nursing profession serves (Bowen et al., 2000; Iwasiw et al., 2009; Keating, 2011; McAllister, 2001). In New Zealand in the 1930s, a different factor led to curriculum change — the need to protect nurses' health. Occupational health in nursing was an international concern and focused on tuberculosis.

This historical research study explains how New Zealand's chief nurse, Mary Lambie, whose career demonstrated her keen interest in public health, used this worry over tuberculosis to improve occupational health in nursing more broadly. A key initiative was curriculum change in the national three-year nurse training programme. Through this, Lambie hoped that nursing would become a less "hazardous profession" (Lambie, 1939, p.67).

This curriculum change was therefore a direct response to an identified and significant problem within the profession. Significant issues facing nursing today can also lead to curriculum change. The profession is acutely aware, for example, of the global nursing workforce shortage. In some countries, related problems in nurse retention are often associated with conflict and adversity in the workplace and can be addressed in part by building nurses' resilience. There is therefore still a need for nursing curricula to promote nurses' health as much as in the 1930s, this time broadening the self-care focus to include resilience (Jackson et al., 2007; McAllister and McKinnon, 2009).

Background

Previous historical research on curriculum change in nurse training has not identified nurses' occupational health as an influencing factor. In one study of a century of change in American nursing curricula, for

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example, occupational health did not appear to be a driver for change even in the period when tuberculosis was a major health issue (Flood, 2011). In addition, significant wide-ranging studies in the history of nursing have paid scant attention to nurses' health. It was mentioned only in passing, for example, in Susan Reverby's (1987) study of American nursing, 1850–1945. The few historical studies specifically of occupational health in nursing have tended to focus on tuberculosis. In relation to the history of nursing in New Zealand, two studies addressed tuberculosis as an occupational health issue between 1900 and 1950 (Allen and Brister, 1989; Paterson, 1990) and another referred to it in relation to acceptance for nurse training at one hospital in the 1930s (Dunsford, 1996). Two other studies, on a broader range of occupational health issues in nursing, located attitudes to nurses' illness in the context of the nursing culture in Britain, 1890–1914 (Palmer, 2012) and New Zealand, 1903–1923 (Wood, 2011). All these studies addressed cross-infection in nurse training but did not identify a significant occupational health issue as a cause of curriculum change.

Although a broad range of infectious diseases affected occupational health in nursing, it was tuberculosis that provided the leverage for curriculum change in New Zealand nurse training in the 1930s. This historical research study analysed the primary historical sources of international nursing occupational health reports (1930s), Lambie's annual reports (1932–1950), and questions and examiners' comments in a new state examination (1940s–1950s), to identify the reasons for and direction of the curriculum change and its connection with occupational health. Findings were interpreted in relation to both historical and secondary sources on other curriculum changes, other measures to address occupational health issues in nursing, and the public health context at that time.

Nurses' Health

In 1937 the International Council of Nurses (ICN) published its analysis of the first year of data, 1934–35, in its international survey of occupational health in nursing. The survey had drawn data from 371 training schools across 20 countries. It had also included health data on the countries' trained nursing workforce. Tuberculosis was the major cause of death. In the year 1934–35, it caused one fifth of student nurse deaths and one third of trained nurse deaths. However, three important points are evident. Firstly, the numbers were not large. Tuberculosis accounted for 12 of the 59 student nurse deaths and 14 of the 45 trained nurse deaths. The low numbers could be explained by the fact that the survey had incomplete data from many countries. Nevertheless, the level of international concern around tuberculosis and nurses' occupational health was arguably out of proportion to the data. Secondly, the morbidity data showed that of nurses with any form of infectious disease, 85% were student nurses. This is not surprising, as in many countries like New Zealand hospital care was delivered mostly by nurses in training. Thirdly, it could be argued that other infectious diseases such as typhoid and scarlet fever collectively had a greater impact. Nine student nurses had died from infectious diseases other than tuberculosis in the year 1934–35. From the morbidity data, almost eight times as many student nurses were affected by other infectious diseases than by tuberculosis (5.5% compared with 0.7%). Tuberculosis could affect a sick nurse for a longer period as treatment could take months rather than, for example, the six weeks a sick nurse would be isolated with scarlet fever. Nevertheless, despite the more extensive problem with other infectious diseases, the survey report focused almost entirely on tuberculosis (Pietzcker et al., 1937).

Only five of the 20 countries that participated in the survey provided statistics from all their training institutions. New Zealand was one. The chief nurse in New Zealand was Mary Lambie in her central government department position as the Director of the Division of Nursing in the Department of Health, in the capital, Wellington. She was nationally responsible for all matters related to nursing, including the nursing workforce, hospital inspection and nurse training. The Nurses Registration Act 1901 had introduced an apprenticeship-style, three-year nurse training programme for all training hospitals in New Zealand, culminating in a state examination leading to state nursing registration. In her ex officio role as Registrar of the New Zealand Nurses and Midwives Board, she was also responsible for all state nursing examinations.

Lambie was a staunch advocate of public health measures and disease prevention. Her lively interest in the matter and her jurisdiction over all training hospitals ensured that they had all supplied the information for the ICN survey. Perhaps because of this, and because she was in contact with the ICN on a Rockefeller Foundation travelling fellowship in 1937, she was invited to join the committee. She became co-author of the international study and helped present it at the ICN Congress in London in 1937 (Lambie, 1937b, 1938; Pietzcker et al., 1937).

Lambie's unfaltering focus on public health and disease prevention was evident throughout her career (Campbell, 1976; Lambie, 1956). She became a registered nurse in December 1913. After time away from nursing for family reasons, in 1918 she joined the Christchurch branch of the School Medical Service. In 1925–26 she completed a one-year course in public health at the University of Toronto. Then, as an inspector in the Department of Health's Division of Nursing, she surveyed health conditions in rural areas and taught the public health component of the department's course that prepared registered nurses for specialised roles. In 1931 she became the Director, Division of Nursing (Lambie, 1956).

In 1932 the Department of Health identified tuberculosis as an occupational health problem among nurses. This was spurred by the recognition that nurses had a higher incidence of it than women in the same age group in the community as a whole (Maclean, 1964). A special committee was set up to study the problem and measures were introduced to monitor, protect and strengthen nurses' health. Lambie was aware that the question of occupational health in nursing required broader consideration than the focus on tuberculosis. The ICN study showed that in New Zealand in the year 1934–35, more than three times as many student nurses had sickened with other infectious diseases than had contracted tuberculosis (4.4% compared with 1.3%) (Pietzcker et al., 1937). Lambie and her department colleagues decided to carry out a parallel five-year study of their own. This showed the continuing occupational health problems related to a broad range of illnesses that particularly affected pupil nurses (as student nurses in New Zealand were called at this time). Lambie's annual reports show that she continually urged hospital boards to take measures to protect and promote nurses' health and had incremental success in achieving these (e.g., Lambie, 1936, 1938, 1939). In a special section on nurses' health in her annual report in 1933, Lambie noted that many institutions were reluctant to conduct regular health examinations on the grounds that they would "make the staff hypochondriacs". She countered that these examinations, in addition to monitoring nurses' health, were "excellent opportunities for teaching personal, preventive hygiene" (Lambie, 1933, p.34). This was her focus. In summing up the situation in 1939, Lambie reported that much remained to be done. Better teaching of personal hygiene, and better supervision of nursing techniques in general, would do much to make nursing a less "hazardous profession" (Lambie, 1939, p.67).

Nurses' Health and Curriculum Change

To protect nurses' health, Lambie believed that pupil nurses needed to be better prepared before they entered the wards. In 1933 she reported that in the first months of nurse training, all pupil nurses would have classes in personal hygiene, and elementary bacteriology in relation to cross-infection. As it was "the junior nurse who in the majority of instances handles all infectious material", each "should clearly understand the dangers to which she is exposed" (Lambie, 1933, p.34). In hospital boards that could not afford the cost of a preliminary training school, pupil nurses attended a series of doctors' and matrons' lectures in their off duty time and ward sisters ensured clinical instruction in the ward setting.