The getting of wisdom

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Contents

The Judith Cornell Oration X
2016 Judith Cornell Orator X
Australian College of Operating Room Nurses X
The Getting of Wisdom X

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Cover: Carollyn Williams, 1971, Prince Henry’s Hospital, Melbourne, Graduation as a Registered Nurse.
The Judith Cornell Oration

The Judith Cornell Oration is a biennial event initiated by the Australian College of Operating Room Nurses in 2002. It is intended to serve as an occasion of celebration for the achievements of Australian perioperative nurses and to allow future visions to be shared.

Orators are distinguished perioperative nurses who, throughout their careers have made a significant contribution to advancing perioperative nursing in Australia.

Judith Cornell AM, after whom this award is named, is one such a nurse. Judith was one of two NSW Operating Theatre Association representatives to attend the inaugural planning meeting held in Melbourne in 1975 that led to the 1977 Australasian Conference of Operating Room Nurses being held in Canberra. Judith chaired this conference, at which it was decided to form the Australian Confederation of Operating Room Nurses, ACORN. The inaugural meeting of ACORN was held the following year, with each of the six Australian states, as member bodies of this national body, sending two representatives.

Judith was the first chair of ACORN and served on council for many years. The purpose of this national body was to look into all aspects of nursing practice in the operating room and to that end, ACORN produced its first Standards, Guidelines and Policy Statements in 1980.

Following her retirement from perioperative nursing in 1986, to take on other challenges, Judith was made a life member of the NSW Operating Theatre Association Inc. ACORN salutes the achievements of Judith Cornell, AM and the outstanding contribution she made to perioperative nursing in Australia.
Australian College of Operating Room Nurses

The focus of the Australian College of Operating Room Nurses is the improvement and standardisation of perioperative nursing care through education and support.

ACORN comprises the various state and territory perioperative nursing associations, which are branches of ACORN. These perioperative nursing associations were mostly formed during the 50s and 60s. The original purpose of the national body was to ‘look into all aspects of nursing practice in the operating room and to organise and conduct a national conference ... to bring operating room nurses together on a national level to discuss operating room nursing issues.’

While there have been many changes in the organisation over the years, ACORN’s core business and values remain unchanged.

ACORN produces Standards, Guidelines and Policy Statements for perioperative nursing practice and has identified and developed competency standards for perioperative nurses.

ACORN also produces a journal quarterly and maintains a website as a means of communicating and informing its members about issues of concern and interest to perioperative nurses nationally.

ACORN is represented on a number of Australian Standards and other committees providing a perioperative nursing perspective as required. This enables perioperative nurses to be seen as active participants within the current and future health arena.
2014 Judith Cornell Orator

Carolyn Williams
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Carolyn undertook her nursing training at Prince Henry’s Hospital in Melbourne. She has worked in perioperative nursing as a clinician and Unit Manager, beginning her formative perioperative experience at the Wellington Hospital in New Zealand and then continuing at The Geelong Hospital, Barwon Health, Victoria. For eight years Carolyn worked as an instrument nurse and surgeon’s assistant for surgeons that included general, vascular and orthopaedic surgery. For 18 years she has worked in nursing education teaching perioperative courses at a hospital level and at Deakin University where she was involved in the development of a new Graduate Certificate/Graduate Diploma curriculum in perioperative nursing and wrote the Nurse Practitioner sequence of the Masters course. For the past seven years she has also been Clinical Placement Coordinator for nursing students at Barwon Health. In this role she has worked with indigenous students who come from all over Australia to undertake the Bachelor of Nursing course through Deakin University’s Institute of Koori Education. In 2015 Carolyn was granted a Life Time Achievement award from Barwon Health.

Carolyn became a Fellow of the Australian College of Nursing in 2004. Carolyn’s Master’s thesis, entitled Uncovering Concepts of Care in Perioperative Nursing Practice, explored the nature of perioperative nursing using a phenomenological methodology that endorsed the need for nurses in all perioperative roles. She has been a regular member of the Australian College of Operating Room Nurses (ACORN) Standards review working parties. In 2006 Carolyn was the Project Manager for the review of the ACORN Competency Standards for Perioperative Nurses and developed a toolkit for their use. In 2008 she received the ACORN Excellence in Perioperative Nursing Award and Fellowship of ACORN. In 2010 Carolyn completed writing the history of the Victorian Perioperative Nurses Group (VPNG) Unmasked – the first 50 years. Carolyn has been a member of the VPNG committee for 10 years serving as Chair of the Education Subcommittee. She is a life member of the Group. Carolyn completed a four-year term on the ACORN Board that included Chair of the Journal Committee and two years as Honorary Secretary. She is currently the Chair of the Censor Panel for the admission of ACORN Fellows.
The getting of wisdom

The ACORN Board, Fellows and Members of the College, my family and perioperative friends and colleagues –
good morning.

I am very proud to be delivering the 8th Judith Cornell Oration and join the group of distinguished nurses who have gone before me. I thank the committee of the Victorian Perioperative Nurses Group (VPNG) for believing me worthy of the task and the ACORN Board for offering me the honour.

I should first like to introduce myself according to Koori culture. I have had the unique opportunity to be involved with indigenous students who come from all over Australia to undertake the Bachelor of Nursing course through Deakin University’s Institute of Koori Education in Victoria. I have learned the importance of, when first meeting, sitting together and saying who you are and where you are from. You know I am Carollyn. I am from Torquay in Victoria, which is Wadawurrung country and part of the Kulin nation that surrounds Port Phillip Bay. Bunjil the eagle is their totem. My ancestors came to Victoria in the mid-1800s in response to the prosperity generated by the gold rush and the pastoral expansion of the squatters. My paternal family is urban; my maternal family is rural and through that line I am a fifth generation Australian.

You will see that I have an interest in history and history will be a theme in this address. I have a firm a belief that we must know where we come from in order to know our future path. A statement from the Australian and New Zealand College of Anaesthetists (ANZCA), who proudly display their history at their website, summarises what I believe: history can’t predict the future, but it can provide us with reference points from which we can examine the present to better guide the future1.
In preparing for this oration I turned immediately to those who had delivered the address before me and examined their orations. Each told of their nursing journey and their aspirations for perioperative nursing – each according to their own style. My accomplishments during my perioperative career have not been achieved by myself alone. There have been key people who have contributed to my nursing journey – to my ‘getting of wisdom’.

In Henry Handel Richardson’s book *The Getting of Wisdom* the new girl at school, Laura Tweedle, confronts a school community in which she does not fit. After many trials, she conforms to the system of rules and is finally accepted and succeeds. My journey has not been like Laura’s although, as a nurse fresh from Preliminary Training School and needing to adapt very quickly to the extraordinarily different life of a novice nurse, there are similarities.

Wisdom can be defined as the quality of having experience, knowledge, and good judgement, the quality of being wise. Einstein said ‘wisdom is not the product of schooling but the lifelong attempt to acquire it’. It has been my journey to attempt to acquire wisdom and during that time I have encountered many people who influenced me, offered sage advice and were role models for my own clinical and professional practice.

From my earliest memory I was going to be a nurse and did not waiver from that ambition. I may have been influenced by my aunt being a nurse and marrying a handsome young registrar. On visits to their house where the GP consulting rooms were attached I still remember the clean antiseptic smell, the green sheets on the examination couch and the glass cabinet full of interesting and shiny implements. You may ask: did I consider medicine? No. The stereotype of the time was that men were doctors and women were nurses and university education was a privilege for those who could afford it. Access to university would change by the time I finished secondary school but nursing was then firmly in my sights. I left Geelong to undertake my training at
Prince Henry’s Hospital in Melbourne. I felt the need to broaden my horizons beyond my hometown even though the Geelong Hospital offered first class nursing training.

My GP uncle became an orthopaedic surgeon and during my training years, when there was an opportunity, he would invite me into the operating room to watch him operate. I was introduced to the anaesthetist, surgical assistant and instrument nurse. I was told the value of a good instrument nurse. I have no recollection of meeting the circulating nurse or the anaesthetic nurse. I must have had some instinct for aseptic technique as the circulating nurse did not need to grasp me and chastise me for breaching the sterile field. I suspect I just stood glued to the wall.

My aim was to complete my nursing training – one certificate – then find a suitable hospital to complete a midwifery course – two certificates – and ultimately complete infant welfare nursing – three certificates. To be a ‘triple certificated sister’ was considered the top of the nursing career ladder. However just as I was planning to go to Perth to undertake midwifery I met my future husband Raymond and, as they say, the rest is history.

Two stories I shall recount from my training days that have remained in my mind as key learning points, one at either end of my training.

For my very first rotation I was placed on a neurosurgical ward. I had no concept of how ill and dependant people could be when affected by neurological conditions. It was almost my demise as a nurse and on my first trip home I vowed never to return. However a sensible and comforting mother convinced me to continue.

Preliminary Training School was delivering care to mannequins and it did not prepare you for the reality of the complexities of care encountered on a neurosurgical ward. One role of the first year nurse was to prepare and deliver extra fluids to patients. A young man with an acquired brain injury was one of my first encounters. He had limited ability to speak as he had a tracheotomy
stoma covered with a piece of gauze. He was on fluid intake and after taking his first mouthful he coughed violently and fluid dribbled from his stoma. I was in shock and thought that I was mistaken, that he should not have been given fluid. What damage had I done! Fortunately, his mother was at his bedside and after seeing my look of terror said: ‘Do not worry, nurse, he does that all the time’. I knew nothing of the anatomy of the throat and neck – that was second year theory – I knew nothing about tracheostomy tubes – that was third year theory – and I certainly did not know anything about weaning from a tracheostomy and swallow assessment.

My second story is from third year. Following finals exams and attaining a pass, third year nurses were often in charge of wards on the weekends as they were deemed able to manage the less complex activities of weekends. I was working on a thoracic ward and this particular Saturday morning the thoracic surgeon was coming in to put in an intercostal catheter. I was confident I could manage this procedure and indeed had been asked to set it up for the finals practical exam.

The procedure was performed successfully and the surgeon stood on one side of the bed assessing the patient and I stood on the other awaiting post procedure orders. The surgeon was Dame Joyce Daws. Dame Joyce was an imposing woman with a stern face and a loud voice. I expect she needed this demeanour to survive in the world of male surgeons. She was for many years a member of the Victorian Nursing Council (which became the Nurses Board of Victoria). I was certainly in the presence of someone important. As she was talking soapy bubbles started to come from under the bed. I looked aghast and waited for the booming voice. However, Dame Joyce, at first nonplussed, started to laugh. The fluid to be placed in the bottle contained an antiseptic agent to neutralise the secretions and was ostensibly called ‘underwater seal drainage fluid’. I had mistakenly used cetramide fluid and thus with every breath the bubbling caused soapy suds that oozed from
the short vent tube. Fortunately the tubing clamps were safely placed beside the bed, the tubing was clamped and another bottle with the correct fluid assembled. No harm was done to the patient or the nurse!

The rotation to the operating suite was during third year. I can still recall the sights, smells and sounds of that operating suite where I knew, almost immediately, that I had a passion for this type of nursing. One recollection of something from the operating suite that perhaps helped shape my development into a perioperative nurse. I was at reception one evening when a young man with a compound fractured tibia and fibula was admitted, his leg in a large bloodstained splint. The young man called my name and I quickly realised he was someone I knew from my rural family background. He was in a great deal of pain and extremely anxious; however, once he saw my face, he smiled. I grasped his hand and held it until I was no longer required and anaesthetic preparations took over. I was not immediately aware of the significance of this action but I would come to know the importance and value of patients having a familiar face in the operating suite. This would happen in my formative years in the operating suite, again when I worked with surgeons and in my own research into care in the operating suite.

As I have told you I met Raymond, a New Zealander, toward the end of my training and I had experienced the passion for operating room nursing. Thus I travelled to the Wellington Hospital in New Zealand to begin my formative experience.

I worked in ‘children’s theatre’, a suite of two operating rooms so named as it was situated on the same floor as the paediatric ward. It undertook predominantly obstetrics, gynaecology and orthopaedic surgery. The nurse in charge was Pam Marley. Pam was a wise and precise person from whom I learnt perseverance and attention to detail. She was also a patient teacher. I was soon confident and proficient in caesarean section and Charnley total hip replacements. We commenced a pre-operative visiting program for the gynaecology patients. This involved the instrument or circulating
nurse assigned to the case. In New Zealand the assistant to the anaesthetist was a technician and, as I had no other knowledge, I considered this to be the norm. The visiting program was largely successful with its biggest shortcoming being getting the time to make the visit. An added benefit was that when you visited the patients for the next day you invariably saw your patients from the day prior. This was a positive experience for both you and the patient.

An historical anecdote from those days: the New Zealand operating room nurses then had only two regional groups, in Wellington and Auckland, and infrequently met face to face. Pam Marley commenced a newsletter to keep all informed and it was called The Dissector, the forerunner of the New Zealand perioperative journal.

After two years I returned to Australia, to marry Raymond, and to my hometown of Geelong. I presented myself to the operating suite at the Geelong Hospital with resumé in hand and asked to speak to the manager. A tall imposing woman in a white theatre dress was busily receiving patients, taking phone calls, giving instructions, speaking via intercom, writing messages and was completely in charge of her domain. She was Mary Barry the Operating Suite Manager. I must have been assessed as suitable as she said: ‘We are about to go into Christmas closedown and we open again in January. Can you start then?’

Mary was a remarkable person and a nursing leader. Mary encouraged, prodded and supported her staff to engage in continuing education and to be professionally and politically savvy. I learnt from Mary not only the importance of education and professionalism but also integrity and equality in professional practice. I joined my professional nursing organisations.

Under Mary’s leadership and that of her second in charge, Jeanette Cuttler, a course was established to teach operating room nursing practices.
I was one of the first group to complete the 12-week course. Lectures were delivered by Mary, Jeanette, surgeons, anaesthetists, pathologists, microbiologists, and biomedical engineers – a diverse range of expertise. Mary, who was a member of the VPNG committee, would also periodically round up staff into a car and take us to the VPNG meetings in Melbourne where they had a guest speaker. On the day of the annual VPNG conference she would arrange for elective surgery to be reduced to urgent cases and send as many as possible to the conference. Such was the importance placed on education for the nurses. It was a bountiful learning environment. In this setting I rose to the position of Charge Nurse.

It was during this time that the inaugural Australasian Conference of Operating Room Nurses was held in Canberra in 1977. In 1971, a seminar titled ‘Safety measures in the operating theatre’ was held in Melbourne by the Royal Australasian College of Surgeons (RACS) in association with the Faculty of Anaesthetists. It provided a venue for a number of interstate operating room nurses to come together, for the first time, and demonstrated that there were considerable differences in policies, procedures and practices.

In 1975, Mary Barry put forward the idea of a national conference to the VPNG Committee and, by December that year, a group of ten operating room nurses from across Australia met in Melbourne to discuss the
possibility. New Zealand was also invited to join. This meeting included Judith Cornell from the New South Wales Operating Theatre Association (OTA). Judith Cornell was elected as chair and Mary Barry as secretary/treasurer of the conference committee. The acronym ACORN was originally chosen to signify the Australasian Conference of Operating Room Nurses. There was forethought that if an organisation were to be formed, it could be changed to the Australian Confederation of Operating Room Nurses. The conference logo was designed by Jeanette Cuttler and later adopted as the ACORN logo. I was there for the ‘birth’ of ACORN and its logo so it is a special symbol for me.

At the conference the delegates unanimously voted to form a national organisation, and state representatives spent a day formulating a constitution, financial guidelines and organisational format. Ten resolutions were taken during the conference and these formed the basis of the ACORN Standards that we know today.

It was an extraordinary experience to attend this conference, be part of the birth of ACORN and experience the networking with national and international delegates. I was able to be reacquainted with Pam Marley, my first mentor, who attended the conference and delivered a paper. And this is a timely reminder to all that May 2017 will be 40 years since that inaugural conference.

Overall, in my formative years at the Geelong Hospital it was a privilege to be influenced by the remarkable leadership of Mary Barry. My memories of Mary are a formidable manager, an exemplary leader and a colleague with a sense of humour.

Following the birth of my daughter, Sarah, I returned to the operating suite at the Geelong Hospital now working evening shifts in charge of the emergency operating rooms. This was a rich and rewarding learning experience over five years. I had the autonomy to run the evening list, manage the staff and collaborate with surgeons and anaesthetists. It was at first daunting to rely on my decision making alone and to make decisions determining urgency, timing and allocation of resources
and staff. Bill Crosby, Director of Anaesthetics, with whom I shared many shifts, was a wonderful mentor. He was straight as a die, often stubborn and enjoyed discussion and debate. I learnt from Bill to think laterally and to back my own judgments especially during those pressure times of cases backing up and more coming in.

When Sarah commenced school I required more child friendly hours. I was fortunate to be offered work as practice nurse and instrument nurse with a general and vascular surgeon, Geoffrey Royal, with whom I worked for eight years. Geoffrey was a passionate and talented surgeon with a natural capacity to teach. I learnt from Geoffrey not only about conditions requiring surgery, the anatomy, the surgical techniques and the post-operative care, but also about people – about the emotional care of people facing and recovering from surgery, particularly cancer. To be able to meet the patients prior to their surgery, then be that friendly and familiar face when they arrived in the operating suite and, later, to be involved in their aftercare was the most rewarding time of my journey.

During this time I took on another position as surgical assistant to orthopaedic surgeon Bill Huffam. Bill was technically the most accurate surgeon I have ever seen. He expanded his work to include the private hospital and was vehemently of the opinion that the patients’ GPs, who would come to assist, had no idea of aseptic technique.

Thus he wanted an operating room nurse! I worked for Bill for five years where we would at times complete three total joint replacements in a day. I learnt the stamina and precision required for surgery. However, I have completed my last joint replacement and do not need to be involved in any more.

Geoffrey would sadly die from a glioma and around that time I was offered a position again at the Geelong Hospital to teach the new hospital-based perioperative course. Geoffrey’s advice was to grab hold of it with both hands. And so I embarked on a teaching role and
quickly found that a good clinician does not easily become a good teacher. It was a steep learning curve. I commenced postgraduate study to enhance my own learning.

I undertook my perioperative certificate course through the NSW College of Nursing. This course was a boon to experienced nurses working in regional and rural locations across Australia enabling them to validate their nursing experience with formal qualifications. The course allowed for reflective practice which enhanced my own practice and gave me the confidence and the tools to study at a tertiary level – something I once would not have thought possible.

It was now I met Gwenda Peters, from Deakin University, who coordinated the perioperative course. Gwenda became my mentor as I began at graduate diploma level and advanced through to Masters. Gwenda also guided me professionally and involved me in the VPNG Committee and university work where I would eventually teach and write both perioperative and nurse practitioner curricula. From Gwenda I learnt reasoned judgement and the importance of process.

Dr Heather Jarman, a midwife by background, was my supervisor for my thesis and was my enabling companion during my research adventure. From Heather I learnt that I had the ability to do whatever I wanted. Completing my thesis, which was designed to demonstrate the importance of the caring practice of nurses in all perioperative roles, has been another rewarding highlight of my journey.

I coordinated the hospital-based program at the Geelong Hospital for nine years where 66 students successfully completed the course. The curriculum contained 390 theory hours and grew to be more inclusive of the roles of anaesthetic and post-anaesthetic nurses.

I was keenly aware that the course must be representative of all perioperative nursing roles. Nurses came from regional and rural areas to undertake the course and when they returned to their hospitals they
needed knowledge and skills in all roles, including managing the sterilising unit. As I became aware, this was something that was not readily achievable in tertiary courses when I commenced teaching at the university. University courses had approximately 160 theory hours and with the advent of online learning this further decreased those face-to-face teaching occasions – those distinct opportunities for discussion, reflection and mentoring. The hospital course became a university program with Deakin University. I first taught sessionally and, after Gwenda left, I was appointed to a joint course coordinator position. However, I would eventually return to hospital-based education utilising newly found Practice Development methodologies in my teaching role.

Practice Development is a key concept that has contributed to my professional practice. I attended Practice Development School and later master classes to enhance my role as a facilitator. Practice Development began in the United Kingdom as a model of change and development for health care practice that incorporates evidence-based practice, quality initiatives and the tools to facilitate change and achieve outcomes\(^3\). The Practice Development School was held at Mary MacKillop Place in North Sydney where the Mary MacKillop memorial chapel and her remains are situated. The chapel is a place of pilgrimage for thousands of people who come to pray and reflect at her tomb. I do not know whether it was my time spent sitting on the seat beside Mary’s tomb doing my own reflection and taking in the spiritual atmosphere of the chapel or whether it was because it was the same place that two Popes had sat and said prayers for Mary; however, Practice Development was for me an epiphany. My focused changed from teaching techniques to facilitation of learning techniques. The methods I learnt and the tools I collected to be a facilitator of learning have been of great value in my more recent practice.
You get to a stage in your career when you are no longer looking to the next learning challenge but are beginning to reflect on what has gone before. It is a subtle transition from ‘What do I still need to achieve?’ to ‘What have I learnt and what do I have to offer? In my clinical practice I went from novice to expert to advanced practice. In my professional practice the transition was ‘a process of becoming’, from being the mentee to being the mentor. I found affinity with the grey gorilla syndrome as described by Pyles and Stern4.

Pyles and Stern asked how do nurses learn and their research revealed new nurses learn to make assessments and sound judgments about care from a more experienced nurse who supports and teaches them during a mentoring relationship. That relationship they termed the grey gorilla syndrome.

As the mentor teaches and advises, the mentee gains knowledge and skills; as the mentor moulds, the mentee gains expertise and professional values; as the mentor protects and supports, the mentee gains competency and confidence; as the mentor coaches and guides, the mentee gains problem solving and decision making skills; as the mentor facilitates and counsels, the mentee gains communication and collaboration skills; as the mentor inspires and influences, the mentee gains values and creative skills; and as the mentor motivates and leads, the mentee gains leadership skills and becomes, themselves, the mentor or the grey gorilla.

Those people who had guided me throughout my career had provided me with the necessary attributes that I could now give back to my profession. I had become the mentor and I was also aware that I had become wise. Indeed Aristotle said ‘knowing yourself is the beginning of all wisdom’.

I joined the VPNG Committee for a second time and during that time I was appointed the Victorian representative to the ACORN Board for a four-year term. I believed I now had the experience, knowledge, good judgement and wisdom to contribute at this high level. To be involved in the College is such a professionally satisfying experience that realises self-fulfillment and
satisfies personal growth. It also provides you with lifelong friends who travel the road with you and share the triumphs, and low points, of the journey. Being a member of the Board provides a unique opportunity to give back to perioperative nursing. As immediate past President Ruth Melville said in her outgoing report ‘it is not just about the person but the greater good that you do’\textsuperscript{5}. I highly recommend getting involved with your state or territory group and to have aspirations to contribute at the national level and even beyond.

VPNG appointed me to write their 50 year history and what an odyssey it was. I commenced the manuscript as a two-year project and was also given the responsibility to arrange the publication of the book.

However, I did have some companions along the way. The first was June Allen, inaugural Chair of the then Theatre Sisters Section of the Royal Victorian College of Nursing. June is a very distinguished nurse. She had her beginnings in operating room nursing and operating room nursing is still close to her heart. I am honoured to say that June was my mentor for the project from the time I first discussed the book with her through the stages of proof reading and to the launch of the book. June wrote the foreword. June has the uncanny ability to ask the right question at the right time that enables you to rethink and solve a problem. The other companions I had were those previously on the committee and past members who enthusiastically contributed their voice to the book. I was able to be reacquainted with Mary Barry and have her recognised by the College who bestowed an Honorary Fellowship on her for her contribution to the beginnings of ACORN. I asked Mary what her motivation was for suggesting that first national conference and she said she just desired things to be bigger and better.

My journey through perioperative nursing has been influenced by significant people I have been privileged to meet and to work with: wise nursing and medical leaders who have shaped my clinical and professional life. I could now reflect not only on my journey but my getting of wisdom. Therefore what have I learnt?
I have learnt that nurses are the only people appropriate to care for patients in perioperative settings. By ‘care’ I mean the process of, or responsibility for protecting and giving special attention to a patient. As we know perioperative settings have a multidisciplinary team, including ancillary personnel, and all these personnel are integral to how the system functions. However, there are roles in these settings that are firmly within the ontological domain of nurses alone.

In commencing my own studies I came across a statement from the Association of Operating Room Nurses (AORN) in the USA. It was a resolution made at their annual congress in 1975 and I believe it still holds true today. Its premise is this: ‘patients undergoing surgery experience physical and psychological trauma; they are completely powerless and unable to make decisions concerning their welfare. At this critical time, patients need much more than technical caretakers; they need professional nurses’.

This resolution became a mantra for my teaching and for my strategy to ensure all perioperative nursing roles were covered by the curricula. It also informed my passion for promoting recruitment to perioperative nursing. It was subsequently validated by my own qualitative research that aimed to uncover caring concepts in perioperative nursing practice.

In Australia we are in the unique position of having nurses working in all perioperative roles. However roles in perioperative nursing have evolved by necessity, rather than by design and vary from country to country. In the USA instrument technicians entered the operating suite workforce during the Second World War and remain firmly established in the instrument role as certified surgical technologists (CST). In the United Kingdom (UK) workforce studies conducted in the 1970s and 1980s recommended non-nursing personnel enter into what were traditionally nurses’ roles. Operating department practitioners (ODP) are now regulated and are able to work in all roles in perioperative services.
In Australia, it is the assistant to the anaesthetist role that is shared between nurses and technicians. Anaesthetic technician roles had developed whilst nurses were concentrating on other roles and technician use or non-use is based on historical workplace arrangements and anaesthetist preferences. Awareness of the need for anaesthetic nurses evolved as the complexity of anaesthetic procedures and equipment developed. The Royal Melbourne Hospital first employed a nurse in the mid 1960s to assist with difficult anaesthetic cases. VPNG in their standards for practice written in 1969 recommended that assistance to the anaesthetist should be readily available. In 1982 ACORN developed the guideline on the role of the anaesthetic nurse. By 1986 the Victorian Society for Post Anaesthetic and Anaesthetic Nurses (now the Australian Society for Post Anaesthetic and Anaesthetic Nurses) was formed. The Australian and New Zealand College of Anaesthetists wrote their guideline for the assistant to the anaesthetist in 1989. However, it was not until the 1990s, with the advent of postgraduate programs in perioperative nursing, that specific anaesthetic streams and courses were introduced.

In New Zealand, there are 700 anaesthetic assistants of which 90 per cent are technicians and 10 per cent are nurses. The Perioperative Nurses College of New Zealand developed a document on the knowledge and skills required for the nurse as assistant to the anaesthetist in response to an identified anaesthetic technician shortage.

It was considered more appropriate to give nurses further skills in this role and from 2015 registered nurses could enrol in a course for assistant to the anaesthetist. This course now continues into 2016.

My own research has confirmed for me that perioperative nurses deliver care to patients, by either direct or indirect nursing activities, and these activities have the potential to influence the health care outcome for the patient. An overarching framework of ‘being there’ became the basic premise, that the presence of
nurses in the perioperative environment is fundamental to the care of patients and provides patients with a sense of being able to cope, feel safe and be treated as an individual\(^\text{10}\).

One anaesthetic nurse in my study explained it thus:

> It is very important to have a nurse close to these patients having this [carotid endarterectomy] surgery, under local anaesthetic, and to be their voice as they do not think they have any say in things happening to them because they are pressed to the bed and stuck under the drapes. The nurse is there to closely monitor the patient, without any machines, by his/her voice or facial expressions and relay this information to the anaesthetist and surgeon who are concentrating on other things.

‘Christina’ in Williams, 2002\(^\text{11}\)

These are heartening words to a researcher wishing to answer the question that intended to uncover caring concepts in perioperative nursing. The major concept of ’being there’ was therefore proffered as a significant factor in validating the role of the nurses. The presence of the nurse provides the humanistic face for patients in a highly technical, critical care environment.

Now, I know I am preaching to the converted in relation to the care that perioperative nurses provide. However, to ensure recruitment to our settings we must ensure that perioperative nursing practice remains an option for nurses and that there is appropriate education available for them at undergraduate, entry, and postgraduate level in universities and hospital-based preparation for practice programs.

Exposure to the perioperative environment in current undergraduate nursing courses is not obligatory; however, it may be available as an elective subject. Where health care services have a relationship with a university providing undergraduate education it can
be possible to assist with recruitment of nurses to perioperative nursing. Students can be placed in the day surgery unit, pre-admission service and the post anaesthesia recovery unit (PARU) as a proxy ‘surgical rotation’. They will invariably get the opportunity to see the intra-operative environment. Intra-operative placement is problematic when students have had no theoretical or practical preparation for the roles. Nor does intra-operative experience meet the objectives of a surgical placement. Thus an undergraduate surgical elective is vital. However, exposure to perioperative nursing is dependent on the availability of it in the curriculum and this in turn is related to the availability of university staff with expertise or an interest in perioperative nursing.

Dr Paula Foran’s recent research into the value of perioperative nursing experience in undergraduate programs examined access to theory and clinical practice. Data revealed that of the 22 universities who replied to a survey one offered an online program, two offered an elective, five purported to offer a mixed mode of study, five said it was covered in the core units and ten admitted to no perioperative content\(^1\). Since this research there has been a further decline in perioperative nursing experience in undergraduate programs and, worryingly, less time spent in perioperative areas means less opportunity for nurses to explore and engage in this area of nursing.

In 2006, the Australian Health Workforce Advisory Committee (AHWAC) report into the perioperative workforce identified the availability of postgraduate courses for perioperative nurses. Within these was one perioperative nurse surgeon’s assistant (PNSA) course. Of 17 universities who had previously offered courses, four had discontinued. Three hospitals still offered programs and also two colleges\(^8\). A more current, yet not in depth, inspection of the internet reveals that ten universities were offering such courses. Six have discontinued since the 2006 data including the PNSA course. One university offers an advanced perioperative
program. One university offers a PNSA stream. One university only offers their program every second year. One college continues to offer a program but no hospitals.

The same AHWAC workforce report also considered the clinical skill-mix within perioperative services that included nursing, anaesthetic technicians and other support staff. Registered nurses make up the bulk of the clinical perioperative workforce. Anaesthetic technicians make up a smaller proportion, but a significant proportion within certain hospitals in particular states and territories. It was estimated that there are approximately 1000 anaesthetic technicians working in Australia. Thus the pendulum is far in favour of nurses. Yet a word of caution! The Industry Skills Council posed two questions given the data found in the perioperative workforce review. Firstly, does staffing of perioperative services continue to rely predominately on the nursing workforce? And, secondly, should the work in perioperative settings be objectively assessed in terms of competencies and skills and new consideration be given to some roles for non-nursing specialist technicians?

Now, I believe it is vital that perioperative nurses continually review and revise their practice. Ask the question: is the role of perioperative nurses task orientated or patient orientated? If the answer is task orientated then others can be trained to carry out those tasks. If the answer is patient orientated, then the holistic nursing approach to care cannot be replaced by technical keepers. Nursing activities are patient-centred activities and nurses are intuitively attuned to patient needs. Patients also attune themselves to nurses. They have need of the human interaction that only nurses can provide. Professor Alan Pearson, that pioneer of evidence-based care said that patients expect nurses to be the ‘humanisers of the health care team, to support them as people as they try to make sense of and come to terms with the situation they face’.
I know the College is very mindful of these situations and they continue working to promote all perioperative nursing roles as the realm of nurses and, most importantly, to ensure perioperative education in these roles is available to nurses. This is something I recommend can be more sustainably achieved via the College collaborating with universities and hospitals. The issue of recruitment and access to education has remained a constant point of discussion in our perioperative history. It has been addressed by previous orators, by researchers and in conferences papers. I note it will be explored in papers scheduled at this conference. It must remain so. As perioperative nurses we must encourage and inspire others to follow on and become the mentors of the future. That is your challenge for the future.

Indeed former Chief Nurse of Australia, Dr Rosemary Bryant, in her oration to the Australian College of Nursing (ACN) forum in Brisbane last year said that strong undergraduate education is needed to adapt to the changing health care environment. Dr Bryant also said ‘it is critical that we maintain the flexibility and willingness to adapt. If we do not, then others will step in and take our profession from us’¹⁶. These are strong words indeed and a remarkable opinion when the context refers to all nursing and not just a specialty.

Thus, I have also learnt that change is not only inevitable but also vital so as to maintain professional strength and vitality. We must identify and act on issues to provide ongoing, effective education for perioperative nurses and be innovative in contributing to raising the profile of perioperative nursing. However, change must be managed appropriately in order to have successful outcomes and ensure sustainability. There are numerous change methodologies and you have no doubt experienced many of them. Practice Development taught me the key concepts of change. The first concept is that evaluation must be absolutely built in from the beginning. You cannot evaluate an outcome if you did not get the process right in the beginning. The second
concept has three components: engage, enable and emancipate.

• Engage the key stakeholders who will likely be affected. Think laterally in this regard.
• Enable the people involved to enact the change themselves.
• Emancipate those involved to sustain the change, give them ownership of the process. The skillful facilitators of the change will then experience success.

Change affects ACORN as it continues to promote and market perioperative nursing. Each board sets strategic goals and these goals reflect new concepts, broadening the range of the College’s influence whilst continually being innovative in meeting the needs of the members and their professional development.

The prevailing factor in the work of the College and the local associations is that most of its work is accomplished on a voluntary basis. The members of the committees and the board join with altruistic aims and give their time freely. They plan, organise and attend events, write Standards, reports and submissions and put themselves forward as the face of perioperative nursing – all with the development of perioperative nursing and the benefit of members as their goal. It is a wonderful legacy and now an ongoing commitment.

However, whilst today some local associations are strong and viable, some have small memberships. They all continue to struggle to meet the recruitment requirements of committees and the board. The sustainability of all the state and territory associations, and thus the ongoing strength and vitality of the board and the ongoing work of the College, is something that concerns me. From Health Workforce Australia’s report into nursing, citing 2012 data, there were over 13,500 registered nurses working in perioperative nursing, approximately 7.3 per cent of the registered nurse workforce. There are over 3900 members of ACORN.
This represents approximately 29 per cent of the perioperative workforce\textsuperscript{17}. I think you will agree there is some work to be done to strengthen membership of the College.

In 1991, a new, enthusiastic perioperative teacher wrote a letter to the ACORN Journal. I suggested that local associations might undergo a name change to include ACORN in their title to reflect the national governance of perioperative nursing. It felt like it was a ‘Mary Barry’ thing to do! I received no feedback at all from this letter, even in the form of stern disagreement. I suggested that the idea be discussed at the upcoming Hobart conference and so it has taken some 25 years for the opportunity to arise in Hobart again. However my premise today is not name changes, \textit{per se}, but to think about inverting the pyramid. To have a robust College representing all perioperative nurses in Australia, with a large and strong membership, it is time to rethink the model and look to the other national nursing colleges in this regard. I do not have a plan for my thoughts but I take this opportunity to water the seed that the board has already planted with the revised constitution so that discussion and debate may occur. British statesman, Benjamin Disraeli, said ‘in a progressive country change is constant, change is inevitable’. ACORN is a progressive organisation and in order to sustain its strength and vitality for the future, change will be required to address the challenges and to empower all perioperative nurses to have the capacity to make decisions regarding their future.

And thus my journey as a perioperative nurse has ended. And as I have reflected on what brought me to this point now and what wisdom I have attained I am reminded of Maslow’s hierarchy of human needs. The formative years were about growth and learning and the need to know and understand – those inherent principles of adult learning. Once I transitioned to knowing, I then had something to contribute, to connect to something beyond my own learning and to help others realise their potential. Then I postulate that I have become wise. Indeed Maslow’s basic position is that as one becomes more self-actualised, one develops wisdom\textsuperscript{18}. 

As I sought inspiration for this oration I sought to explain wisdom. I found an aboriginal proverb and when I remembered that reflective experience at the Mary MacKillop chapel I noticed two things. Mary’s tomb said: ‘remember we are but travellers here’. The proverb says ‘we are all visitors to this time, this place. We are just passing through. Our purpose is to observe, to learn, to grow, to love ... then we return home’\textsuperscript{19}. Such an uncanny similarity. And so I have passed through perioperative nursing and recounted my story in my style. As I return home I trust that I have left you with some wise words to ponder. In closing, may I firstly thank those nursing friends who have accompanied me on this journey and have contributed to me being here today – there are very special ones amongst them.

Finally I want to recount a story from when I spent a short sojourn away from perioperative nursing working at the Royal Flying Doctor base hospital in Carnarvon, Western Australia. Western Australia was holding a referendum on whether to implement daylight saving. The nurses assisted in distributing ballot papers to patients. An elderly aboriginal man was one of my patients that day. He was from the Kimberley region and as a young man had completed a motor mechanic apprenticeship. I explained that the vote was whether or not to turn the clocks back during summer so as to save daylight hours. He looked at me for a moment very thoughtful. Then he said, quite slowly, ‘it would take a mighty big spanner to get up there and move that old sun’. The wisest thing I have ever been told.

Thank you.
References


Orators

2002 Judith Cornell (NSW)
2004 Narelle Hines (NSW)
2006 Bernadette Brennan (Vic)
2008 Dr Lois Hamlin (NSW)
2010 Judith Berry (SA)
2012 Menna Davies (NSW)
2014 Dr Patricia Nicholson (Vic)