Judith Cornell Oration:

Who do you think you are?
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Cover: Sally Sutherland-Fraser in front of the conference room at Randwick Campus Operating Suite when she was CNC for South Eastern Sydney Area Health.
The Judith Cornell Oration

The Judith Cornell Oration is a biennial event initiated by the Australian College of Perioperative 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 Perioperative Nurses

The focus of the Australian College of Perioperative 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 quarterly journal 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.
Sally Sutherland-Fraser
MEd, BEd (Adult Ed), Cert Periop Nsg, Diploma in Arts (Fine Art), RN, MACN, FACORN

Sally has been practising as a perioperative nurse for more than 30 years. As a student nurse at Mona Vale District Hospital in the mid 1980s, Sally was fortunate to enjoy two placements in operating theatres. Sally’s first full-time role came when she settled in London to work in the theatres of the Queen Elizabeth Hospital, part of the Great Ormond Street Hospital for Sick Children. Sally worked in all perioperative nursing roles, cementing her love for the specialty. On her return to Sydney, Sally was promptly back in scrubs, honing her skills caring for sick children at the Royal Alexandra Hospital for Children, Camperdown, affectionately known as ‘the Kid’s Hospital’. Over the next year, Sally progressed through the surgical specialties and learnt about paediatric anaesthetics and recovery. With the confidence of youth, Sally took on weekend night duty and enrolled full-time in Fine Arts at the National Art School. Four years later, after exhibitions and overseas travel, Sally returned to the Kid’s Hospital. She traded her oil paints and brushes for pens and pixels to complete the certificate in perioperative nursing, facilitated by Menna Davies at the College of Nursing NSW, and became clinical nurse educator in 1994. The next few years were very focused as Sally worked her way through a Bachelor of Adult Education. After nearly a decade at the Kid’s Hospital, Sally returned to adult patients as a scrub nurse at Sydney Hospital / Sydney Eye Hospital, in recognition of a practice-gap. Sally subsequently became nurse educator at St George Hospital and then Area Clinical Nurse Consultant for South East Sydney in 2001. Over the next decade, Sally worked closely with visionary managers to shape perioperative practice. Sally also mentored successive new perioperative educators, supporting their growth and career progression. During this time, Sally also completed a Masters in Education.

Throughout her career, Sally has been active in the NSW OTA, with executive roles including NSW representative on the ACORN board. In 2010, Sally was the proud recipient of the ‘Excellence in Perioperative Nursing Award’ and became a Fellow of ACORN in 2012. Sally has an extensive track record as a presenter and writer and has given the roles of researcher and textbook editor a nudge as well, joining the eminent editorial team of Hamlin, Davies and Richardson-Tench for the second edition of Perioperative Nursing: An Introduction.

Sally started shaping plans for her latest career move during extended remote travel and birdwatching across Australia in 2012. On her return to Sydney, Sally established an independent education consultancy with long-time colleague Menna Davies. Over the past five years learning the ropes as a ‘woman in business’ completing a number of successful projects in Australia and the Pacific, Sally has also maintained a casual clinical role. Sally suspects there will always be a place for clinical practice even when she returns to those oil paints and brushes and hits the road once again.
Who do you think you are?

Distinguished guests and visitors, members of the ACORN board, Fellows and members of the College, dear friends and colleagues, it is a great honour for me to deliver the 9th Judith Cornell Oration at this inaugural International ACORN & ASIORNA Conference. I offer my heartfelt thanks to my dear colleagues in the NSW Operating Theatre Association for supporting my nomination, and I hope you quietly share the pride I feel today to join the esteemed company of Judith Cornell Orators.

I wish to acknowledge that we meet today on the traditional Country of the Kaurna people of the Adelaide plains and I pay my respects to Elders past and present. I recognise their cultural heritage, beliefs and relationship with the land and I acknowledge and respect that these are of continuing importance to the Kaurna people living today.

The title of my oration ‘Who do you think you are?’ was, in some ways, an easy choice for me. It comes from the documentary series of the same name, which explores the previously unknown branches on the family trees of well-known people. The series poses this question with an authentic spirit of curiosity about a person’s past and its possible influence on their present. And, so it is with my oration; I am simply looking back at my origins and pondering how they may have brought me to this point today.

There is another slightly longer question that I’ve also been asking myself since I got the call from ACORN president, Sarah Bird, to deliver this oration – ‘Who do you think you are ... to be the Judith Cornell Orator?’
Certainly, I have had many moments of self-doubt about that question! Those doubts bubbled up when I began to think of Judith Cornell and her extraordinary legacy. I took time to consider the stature of previous orators and their contributions to perioperative nursing in Australia. I wondered what I shared with such a collection of eloquent previous orators. Was it our backgrounds or our career paths? Was it our professional achievements or our personal qualities? These questions led me at first to a terrible case of writers’ block!

Well, as you can see I’m here today with more than a few words in front of me, so I found a way through, but only because I resisted the downward spiral of that foolish question. I’ll let others be troubled by that. It’s quite easy then, to simply ask myself ‘Who do you think you are?’ The answer of course is: I’m a nurse.

The reality of this came home to me in a very dramatic way four years ago at Flinders Street Station in Melbourne. The 2014 ACORN Conference had just closed, and I was on my way over to the Melbourne laneways for a last-minute stroll before heading to the airport. On taking my luggage to the railway’s travellers rest, where I planned to store it for a couple of hours, I saw a small group of people leaning over an elderly man who was lying on the floor. One of the staff members was on the floor kneeling beside him. He had pinched the man’s nose and was holding the chin when he looked up at me, then hesitated. In one glance, I could see both his terror and his expectation. At the same time, another staff member raised his palm at me and said ‘I’m sorry, you can’t come in’.

I pushed forward, dragged my bags off both shoulders and dropped them at the door.

‘I’m a nurse, please... I can help you...’

At that moment, I felt the terror lift from the group and land on my chest. In all of my years as a nurse, I had never been the first responder in an emergency and I had never actually performed CPR on anyone. Of course, I’d been teaching and assessing CPR for much of my nursing career. At that moment, all I had to draw on was
theory, I just needed the courage to put it into practice. I knew that every second counted so I dropped to my knees and all of that training kicked in. D-R-S-A-B-C-D. D-R-S-A-B-C-D. My mind was a metronome. I had a protocol and I had energy to burn. Was it ‘fear’? Certainly. Could I use it? Yes, there was no alternative.

I had a quick look for danger – nothing obvious apart from the fact that we were in the middle of the doorway. I tried briefly to get a response from the gentleman, but he was non-responsive, clammy and completely ashen.

I asked, ‘Has an ambulance been called?’ (Yes, the paramedics are already on their way).
‘Is a defibrillator available?’ (Not sure, someone is checking).
‘Does anyone know this gentleman? (Yes, this woman is with him. He’s not long out of hospital for his heart).

I checked and confirmed that his airway was clear, then started chest compressions. ‘So, this is what it feels like,’ I thought. I tried to calm myself and turn my terror into confidence. I was talking to him in my mind, saying I’m with you, I won’t leave you, just stay with me, let’s keep going. His ribs and sternum were creaking under my hands. Eventually the creaking became crunching. My arms and legs didn’t seem to be tiring at all. I know, in reality, they must have been tiring and I know, in reality, that my compressions were probably weakening. It must have been 10 minutes before the paramedics arrived with the defibrillator. Oh, great joy! They asked if I was okay to keep going with the compressions while they put the chest leads in place.

‘Yes, sure, I’m a nurse’.
‘Well, he’s a lucky man. You’ve done a great job, he’s got an output. Let’s get a line in’.

After a couple of shocks, and intravenous meds, the paramedics were happy with the rhythm and they got ready to move the gentleman onto the stretcher. Before we knew it, the paramedics were on their way to the hospital with the gentleman in their care, and
those of us remaining at the travellers rest were left feeling dazed and exhausted amid the debris of the resuscitation. The staff were so grateful. They were grateful that I had not turned away but had pushed through to help, they were grateful that I had stayed calm and grateful that I had helped them to clean up. They were so grateful in fact, they said I had a lifetime’s free storage for my luggage at the travellers rest!

Half an hour later, I was sitting by myself in the Melbourne laneways with a strong coffee in my hand. I had said those words without really thinking about it. Those three words: I’m a nurse. I had said them twice. They felt right. If ever there was a moment when I thought that my nursing career might have distinct ‘bookends’, then this was the moment. I had only just finished up at St Vincent’s Hospital to go out on my own as an independent consultant the week before the conference and was, for the first time in 30 years, no longer employed in the health system as a nurse. The irony of this timing was not lost on me.

A nurse

I never had aspirations to become a nurse. It might seem a shock to say this now but it’s completely true. I had much more adventurous ideas and more creative career aspirations. At some stage in my childhood, fuelled to a certain extent by my mother who always encouraged my artistic leanings, I realised that I wanted to be an artist. I enjoyed drawing and throughout my school years I studied art history, and this passion grew into a strong ambition. How on earth is it then, that I am here today, looking back on my career as a nurse? And, given my thwarted artistic ambitions, how is it then, that I have had such a happy and fulfilling career as a nurse? To answer this, let me tell you a few things about my origins.

My mother had been a bit of a ‘wild child’, expelled from school for meeting boys and smoking. She mixed in some pretty exciting circles including a brief stint in the circus and was a photographic model before meeting my father, getting married and raising two girls. My sister
and I are only 18 months apart and I have no doubt we were loved and nurtured, but our arrival must have been two big speed humps in our mother’s wild ways. My father on the other hand wasn’t what you’d call a wild child, but he did have a truly ‘wild childhood’, growing up on a tea plantation in Ceylon. My father still tells a good story about the pet monkeys and birds and elephants, about the elderly punkah wallah whose efforts kept him cool during the heat of his afternoon nap, and about riding on his motorbike at breakneck speed down crazy mountain roads with his beloved dog balancing on the back. There are photos of my father in this colonial outpost as a young child wearing a pith helmet and hilariously big Bombay bloomers. My grandmother was a British nurse working at the civil hospital in Kandy when she met and married my grandfather. My father’s family tree also includes Dr Charles Nathan who, with Dr John Belisario administered the first anaesthetic in Australia at the Sydney Infirmary in 1847. I think of the wonderful symmetry of this whenever I am in scrubs for a casual shift at Sydney Hospital, and I am looking forward to digging deeper into that history!
My father made his way to Australia as a young man and met and married my mother in Melbourne, where my sister and I spent our first few years playing on the beaches of Port Philip Bay. We later moved to Sydney’s northern beaches, where my father was very active in surf-lifesaving. He was in one of the first crews to jump from the rescue helicopter into the surf below, which required a lot more training beyond the basics of first-aid. We lived near Mona Vale District Hospital and it was there in the Accident and Emergency (A&E) Department that my father spent several weeks in what we would now call paramedical training. The department was managed by Marg Stephens, a remarkable nurse. Her department seemed like a big family of very clever people fixing up broken bodies and it must have laid some deep seeds within my young mind.

During the last few years of school, my mother’s wild ways began to catch up with her and her health deteriorated. She had survived a bout of rheumatic fever as a child and this had damaged her heart, although I had no sense of how serious this was. She had pushed her body to the limit with cigarettes and alcohol, and her heart was giving in. I recall when my mother was admitted to ‘Clancy’, the overflow room in the A&E Department at Mona Vale. I was still in my school uniform, my father had brought me straight to the hospital. I saw a very sick woman in the bed hooked up to oxygen, monitors and drips. I felt the air in my chest disappear and my legs and hands wobbled as I approached her, thinking ... is this really my mother? The nurse realised my sense of shock and my fear. She spoke softly and kindly to me and explained that everything was okay now, and that my mother was going to stay in hospital overnight. What appeared to be catastrophic and terrifying in my eyes was all very unremarkable to this experienced nurse, certainly nothing that she hadn’t seen before, and her serene competence helped me to feel less frightened about my mother’s ill health. I know now, that this experience, of moving from a state of fear and uncertainty to comfort and hope, shaped my ideas about nurses and nursing.
There were other early influences and events that also pushed me towards nursing. I remember when I was quite young playing with some beads. I found that some of the beads were the same size as my nostril. Before I knew it, I had inhaled one of them: it slipped out of my finger-tips and disappeared straight up my nostril. Well, I hadn’t foreseen that! Strangely, as far as I could tell the bead hadn’t hit the inside of my head anywhere. And yet, I thought, it must have gone somewhere. By now, a mild sense of fear was slowly building in me. What should I do? I didn’t want to get in trouble, so I went to the bathroom and locked the door. I sat on the loo and thought ‘Something will happen eventually … but what?’ I must have taken a deep breath, because the bead suddenly popped into my mouth.

‘Wow!’ My relief turned quickly to excitement and fascination. ‘So…’ I thought, ‘…my nose is connected to my mouth, how about that!’

I cleaned off the bead and stuffed it into my pocket, unlocked the door and headed off, completely oblivious to the danger I had created and compounded by locking myself away. Oh, the horror of that now, a child locking themselves in the bathroom with a bead stuck up their nose; it does make me realise that the instincts of small children are not always life-preserving.

The single childhood experience that must have influenced my eventual career path above all else was one that I hadn’t anticipated: the death of my mother. It was summer and I was spending my days on the beach having just completed high school. My exam results arrived and I remember my mother being so excited for me because my results would get me into university. The whole world was opening up for me and she was excited by the possibilities of my future. The next day her weak heart and wild lifestyle finally caught up with her. The ambulance, resuscitation and emergency responders couldn’t save her and she died in the A&E Department at Mona Vale District Hospital. She was 44 years old.
It would be another 18 months before my future finally started. It was July 1981 and I arrived at Mona Vale District Hospital to start my three-year’s training as a registered nurse. This might seem like an obvious future now in my retelling, but I didn’t see it that way at the time. Those 18 months were not so much a lost time or even a waiting time for me. They were a transition from wild childhood ambitions to practical adult realities. I deferred university. The seeds laid down within my young mind by that big family of very clever people fixing up broken bodies in the A&E Department had finally begun to sprout. These like-minded people validated my somewhat shaky sense of self and gave me a glimpse of my future. I recognised that I had found my ‘tribe’.

I was fortunate to enjoy two student placements in operating theatres. I recall a sense of privilege at finally being part of the team behind those closed doors. There was also a sense of wonderment and awe at being so close to the action. The ability to care for one patient at a time was, for me, one of the highlights of operating theatres. After the intense and busy placements on the medical ward I was ready for a new challenge and theatres seemed to suit me. My fellow students included many enrolled nurses (ENs) and my great respect for ENs, to this day, stems from having such positive role models at the start of my career. The ENs differed from me because they were very capable clinicians having been in the nursing profession for some time already. They were also relaxed and comfortable talking with patients and being with patients. Confident really, in just about everything.

By contrast, I was hopeless. I didn’t know the first thing about talking to patients. During our initial six-week study block, our group was allocated to the orthopaedic ward. I was quietly terrified, so I stuck closely to these ENs. I listened to them, watched them and learned from them: I was learning how to be a nurse. Not just any nurse. I wanted to be that nurse in ‘Clancy’, whose serene competence caring for my mother made such a powerful impression on me. The experienced ENs were
a constant source of support and advice for me about the finer points of clinical practice. Jacky, one of my close mates, saw me getting ready to do my first wound dressing. I was scrubbing my hands at the sink and at some point, without actually realising it, I touched my mask to scratch my nose. Jacky saw me do this and gave me a good-natured poke in the ribs and said ‘Oh Sally! Really, you won’t pass if you do that again!’

I asked her what she meant and she told me I’d just touched my mask.

‘Really? No, I don’t think so…’

Well, Jacky was so sure that I had that she must have been right. I know I was nervous about the dressing technique. I suspect that I was also very focussed as I mentally rehearsed the steps I needed to follow setting up for the dressing. At some point I must have lost any sense of what I was doing at the sink so the natural reflex to scratch my nose didn’t break into my consciousness. *How on earth can that happen?* I wondered.

My experience at the scrub sink is something that Endsley describes as a brief loss of situational awareness, a key concept in human factors training. I learnt about this much later in my career when I was the nurse educator at St George Hospital in Sydney. Richard Morris was the director of anaesthesia and he introduced me to error theory and human factors training in a memorable way one morning. I walked into his theatre before the day’s scheduled neuro list was underway. He was standing beside the anaesthetic machine, testing the controls of the operating table. He asked me what I planned to do when the overhead light fell from the ceiling during surgery. *Hmmm…* I thought, *tricky question.* That was probably the last thing I was thinking about until then.

Richard said, ‘Was that the last thing you were thinking about?’
Gee... this tricky guy can also read minds! Richard told me what his plans were for his anaesthetised patient and told me what assistance he would need from me and from the rest of the team. He asked me if there was anything else that I would expect or advise in the unlikely event that the overhead light would fall from the ceiling during neuro surgery. Richard completely captured my attention and my respect from that moment. I learnt more from Richard than I can recount here. He treated me as a true colleague – he was interested in my opinions and actually wanted to work with me and all of the other people in the room. Richard was building a shared mental model. His actions followed the pattern described by Gillespie and colleagues – synchronising the team’s actions, sharing his local knowledge (and checking mine), and making plans to deal with emergencies.

This could not have been more different from my first interaction with an anaesthetist. This was during my student placement at Mona Vale. A senior nurse led me into the general surgery theatre and deposited me at the top end of the table. The surgical team was in the middle of abdominal surgery, chatting with the anaesthetist over the top of the large green drape. The patient was under a general anaesthetic. No one acknowledged my presence until the anaesthetist turned towards me and said, ‘Don’t touch anything. Watch the patient until I come back’.

With that, he picked up his newspaper and was gone. He might have been gone for two minutes or 20 minutes. However long it was that I was there by myself at the top of that table, it seemed to me an eternity during which time the patient was surely dying slowly from any number of unknown and unobserved anaesthetic risks under my inept ‘watch’. I have to concede that there must have been another nurse in that theatre keeping an eye on me and, more importantly, keeping an eye on the patient. But I wasn’t aware of this distant supervision and I recall it as a terrifying experience that nearly broke my spirit. Both the patient and I were fortunate to survive this experience.
I got through many other hard times as a student. There was a culture in nursing at the time that aimed to silence our critical questioning and crush our independent thinking. I was developing some seniority (if there is such a thing as a student nurse) and with that came choices about how I would conduct myself and treat my colleagues. I knew what sort of role model I wanted to be. One quality I valued above all else was generosity. I was drawn to those people who were generous in giving their time to explain and guide, and who were generous in finding opportunities for me to practise my clinical skills. They did a pretty good job, because I was awarded the Hospital Gold Badge when I graduated in 1984. This achievement and my experiences as a student inspired me to develop the quality of generosity myself and it is probably this desire that put me on the path towards the role of educator.

An educator

A year after finishing my training, I headed off to see the world. I felt incredibly lucky to be in a position to do so and pleased that I had chosen a career that could take me anywhere. I eventually settled in London to work in the old operating theatres at the Queen Elizabeth Hospital for Children combining two specialties that I loved – operating theatres and paediatrics. On my
eventual return to Sydney, I was promptly back in theatre
scrubs, honing my skills as an instrument nurse as well
as paediatric anaesthetic and recovery nurse at the
Royal Alexandra Hospital for Children, affectionately
known as ‘the Kid’s Hospital’. There is something about
babies and children that generates, I think in all of us,
another level of care and attention. It might be their
vulnerability to injury and harm that compels us to
stand nice and close as they go off to sleep, with our
hand on their hand. It might be their tears and fearful
struggles that stops our busy and noisy preparations so
we can bring a watchful silence to the room. Whatever it
is, surely all of our patients deserve this care.

In hindsight, I was lucky to work at the Kid’s Hospital
before Lesley Cooke retired. Sister Cooke was referred
to affectionately as both ‘Cookie’ and ‘she who must be
obeyed’. Many of you will know that Lesley had been
President of the NSW OTA and an ACORN Councillor
during the 1980s, so she knew her nursing history; she
knew her perioperative standards and she knew how to
get the best from her medical colleagues. Sister Cooke
would do a round of the operating rooms every morning
acknowledging all of the medical and nursing staff. She
would make it very clear that she was in charge; the
surgeons were visitors in her domain, albeit important
and well-respected visitors. And visitors were expected
to follow the rules – her rules. This of course meant that
we were always following the latest ACORN standards.
All of this set a very positive example for me. It was not
long before I enrolled in the perioperative certificate at
the College of Nursing, with two facilitators who were
to become my lifelong mentors, Kim Bryant and Menna
Davies. With their encouragement, I joined the NSW OTA,
and my real education began in earnest.

Lesley Cooke’s retirement and the relocation of the Kid’s
Hospital from Camperdown to a new site at Westmead
marked the end of an era. The new perioperative nurse
manager, Lesley Pereira was symbolic of a changing of
the guard, not only because she was undertaking a PhD
on surgical handwashing routines but also because she
was one of the youngest managers of a perioperative
department at that time. That can’t have been easy. It’s no surprise that Lesley was a very different kind of role model to Sister Cooke, but she was just as influential in my career, being active as an ACORN councillor and providing me with many opportunities to develop my skills and career pathway. I recall one conversation when Lesley told me that I was going to a meeting at the Department of Health. I can’t recall the details, but I do recall that the level of my surprise at being selected for the meeting was in equal measure to Lesley’s confidence that I was capable of contributing to the meeting.

I was also very surprised when my educator Lorraine Jackson told me she was leaving the Kid’s Hospital and she suggested that I should apply for the position. ‘Really?’ I said; I had never considered being the educator. Well, I am forever grateful to dear Lorraine for seeing some potential in me that I hadn’t yet seen in myself. My application was successful and within a month I was facilitating my first intensive orientation program with a group of five newly graduated nurses. This must have been somewhat of an experiment; not only was
I completely untested as an educator, but the Kid’s Hospital had never employed a group of inexperienced nurses at one time. Teaching and supporting these keen and talented young nurses improved my own knowledge and skills because I could only explain the concepts that I understood myself. Becoming an educator pushed me to learn every day.

Like everyone else, I have had periods of doubt during my career, but never about my authority as a nurse or the value of my role as an educator. I have never formed the view that I’m ‘just the nurse’ and, thankfully, I have rarely worked in places where a culture of such self-limiting views existed. I have instead found inspiring managers and strong nursing leaders who shaped a workplace culture of empowerment, one that valued education and created opportunities for their team’s growth.

‘Train people well enough so they can leave, treat them well enough so they don’t want to’ Deb Cansdell, Bernadette Keenan and Debra Thoms were three exceptional mentors for me in the 2000s who embodied this leadership maxim. It was a decade of hard work.
for me as a nurse educator, completing my Bachelor of Education, and as Area Clinical Nurse Consultant (CNC) completing my Master of Education. It was also professionally very rewarding. These three women expected me to have opinions and ideas. I watched and learned from them how to be confident, not just in shaping my ideas but also in advocating for those ideas. It’s no coincidence that this was also the decade when I was most active within the NSW OTA Executive. I was eventually nominated for a role on the ACORN board by Lois Hamlin, another generous mentor, and I grabbed this wonderful opportunity with both hands. And not just because it meant regular trips to this beautiful city Adelaide! It meant that I had a ‘chair at the table’ and an opportunity to shape practice in Australian perioperative nursing. I learnt what it takes to review evidence and develop ACORN standards and I learnt about good governance, communication and leadership. If you were to look at my colleagues from the ACORN board of 2006, including Sarah Bird of course, you couldn’t fail to be impressed by their commitment and their ongoing achievements. If you are capable of putting in the long hours and hard work, then representing your local association on the ACORN board is a career goal that I would strongly encourage.

An advocate

How do we learn to be more confident as advocates for our patients? For me, it took more than good role models. It took good knowledge and real experience.

Let me tell you about the teenage girl who developed a large sacral pressure injury following a 20-hour operation for a cranial tumour. During that time, the nursing team was replaced and all personnel had rotated through comfort breaks. The surgery was a success; however, within the first post-op day, there were signs of an extensive pressure injury. The wound care CNC asked me about the adequacy of the intra-operative nursing care. On review, it seemed that the nurses had done everything they would normally do and had used all of the equipment they had at their disposal to
manage this young patient’s pressure injury risks. But I was bothered by my own thoughts that the injury was probably ‘unavoidable’ given the extensive surgery and long time on the table. I couldn’t see what else might have been done – it’s not as if it’s possible to stop surgery and reposition patients, is it? Well, that might seem like an obvious question, but instead I should have asked: Do we make use of the existing opportunities to reduce the risks during surgery? I heard Jenny Horwood pose just this question at the NSW OTA conference in 2007 when presenting her paper on the PUPPIES project at the Queen Elizabeth Hospital (QEH) here in Adelaide. Jenny’s presentation made a very strong impression on me because the QEH perioperative team were doing passive limb exercises for patients during some surgical procedures – in other words they were making use of the existing opportunities during surgery to perform simple passive limb movements.

As I sat listening to Jenny I began shaping my own thoughts for a research project at St Vincent’s Hospital in Sydney. It took several years but my colleagues and I eventually published our study of perioperative nurses’ knowledge of pressure injury prevention. So now when I see the anaesthetist place a bag of IV fluids behind the patient’s shoulders I am quietly confident, not just in my knowledge about the clinical practice and latest research, but also in my authority as a nurse to question a colleague’s practice, even when there is a steep authority gradient. The conversation usually goes something like this:

‘Let me give you this gel roll instead’.

‘No, I don’t want that. This is the perfect size’.

‘Sure, the gel roll is slightly smaller but it has actually been designed for patient positioning and for reducing pressure injury risks. The IV bag might be a better size but it has nothing else to offer us. If our patient developed a pressure injury, or even a skin tear from that IV bag when this gel roll was available for us to use instead, well …’
It’s usually at this point that the anaesthetist agrees to use the gel roll. If it seems at all likely that the anaesthetist is thinking ‘Who do you think you are?’, then I will persist because I really want that anaesthetist to know, and to accept, that we are actually working together. I’m still trying to build that shared mental model.

We know that patient outcomes suffer in teams when someone’s voice isn’t heard or the team hasn’t built a shared mental model8. Florence Nightingale fought hard to be heard by army surgeons in the Scutari Barracks Hospital in Turkey and was ignored by army bureaucrats, whose report in 1858 on the conflict in the Crimea was completely silent on both Nightingale and the contribution of her nurses9. Yet we know through her own reports and witnesses that Nightingale instituted changes that improved the sanitation, nutrition and comfort of the sick and wounded. She achieved this by collecting and using statistical information to support her arguments10 which she submitted as written evidence to the Royal Commission into the sanitary conditions of the British Army11. The contents page of this massive report listed the names of all 53 witnesses, including directors general, hospital superintendents, surgeons, engineers and military officers. The final witness on the list was a woman: Miss Florence Nightingale. That’s an impressive list of 53 powerful and influential people, and only one of them a nurse. What confidence, what sense of self and what strength of purpose would that have required, do you think?

I have no doubt that Nightingale was able to answer the question ‘Who do you think you are?’ Nightingale may have been the single voice for nursing at that time, but she had a voice, she used it and she was strategic, using evidence and data to strengthen that voice. Consider this exceptional legacy and the power of our accumulated voices now as nurses advocating for better patient care in the 21st century. Consider this next time
you find your authority as a nurse being questioned. Be confident as you stand your ground. Be confident as you uphold your standards of practice. Be confident because you are a nurse.

**An orator**

If the role of the orator is to use their voice, then I hope that my words today sit well in the eloquent company of previous Judith Cornell Orators. If I have any regrets about my oration, it’s that I have had to make some tough decisions about what to include. I will be speaking at other times during the conference about the project to develop practice audit tools for the ACORN standards and the related project with my colleagues in the Pacific, so I hope you will understand why there are no words on these topics here now. I considered talking about how I came to establish an education consultancy with Menna Davies. I was tempted to talk about learning the ropes as a woman in business, how bold I felt taking that step and the wonderful sense of independence and confidence it has given me. I considered telling you what it was like to be a new editor supporting writers to find their own voice without crushing them with my feedback. And, there is yet more I can tell you about the nurses’ experience in WWI and the power struggles of nurses throughout history.

In the end, this is somewhat self-indulgent, but it does serve a point. There’s not a single achievement in my career that I can claim as my own. Every milestone and proud moment in my career was the result of teamwork. I am here because of the leaders who challenged me with opportunities and who supported me all the way. I am also here because of the people who’ve worked alongside me and inspired me, mentored me and laughed with me. Above all else, these people have been my most generous role models, and for that I am deeply grateful. As for my partner Jenni Wilkins and my family, it goes without saying that their influence is here on every page.
A better nurse

I will finish with a final story from the Kid’s Hospital about a baby undergoing cardiac surgery. It’s really a story about my goal for being a better nurse. A goal I have for myself and a goal I have for you, my colleagues.

I felt well prepared and was very excited to scrub for the baby’s surgery, a complex arterial switch procedure, but I recall very little of the surgery prior to the moment when the surgeon told the team he was unable to get the baby off bypass. I stayed with that wee baby till the end, in the painful silence of that operating room as we washed her and made her ready for her family. I recall my moment of insight – I had been excited to scrub that day because I wanted to prove my worth. I wanted the recognition of my colleagues, but that day meant so much more to that baby’s family. It put my needs for excitement and recognition into stark perspective and reminded me who I was actually there for. That baby, that family, not me. It was a tough way to learn such an obvious lesson.

Every day, someone is waiting outside theatres, holding onto that hope for their loved one. I try to remember this if ever I feel myself entering that zone where the name of the procedure has replaced the name of the patient: ‘Send for the next one’; ‘Are you scrubbing for the hip?’; ‘You have four cataracts this afternoon’. We should never utter these phrases and we should never hear them without seizing that moment to completely reframe our thinking. Being patient-centred starts by using our patients’ names. In the end, it’s really not hard to be that nurse in ‘Clancy’, the one whose serene competence in caring for my mother ultimately taught me everything it means to be a better nurse.

Thank you.
References


11. Herbert S. Report of the commissioners appointed to inquire into the regulations affecting the sanitary condition of the army, the organisation of military hospitals, and the treatment of the sick and wounded with evidence and appendix (digitised archive; Identifier b21365210) [Internet]. London: London School of Hygiene & Tropical Medicine Library & Archives Service; 1858 [cited 2018 April 1]. Available from: archive.org/details/b21365210.
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)
2016 Carollyn Williams (VIC)