THE 45TH PATRICIA CHOMLEY MEMORIAL ORATOR

Professor Tracey McDonald RN, PhD, FRCNA
RSL LifeCare Chair of Ageing
Australian Catholic University

Professor McDonald holds a research chair in ageing sponsored by RSL LifeCare where the many issues arising from an ageing population, ageing veterans and community health are her focus. She has developed what she calls 'practice-driven research', an approach that fully involves clinical nurses and carers in striving to understand the work they are doing and to do it better. Prior to her appointment in 2005 she worked within the aged care industry as Manager of Research and Policy with the Aged Care Association Australia. She remains closely involved with nursing, health services, policy strategies around ageing, social inclusion and building a society for all ages

Tracey has been involved in nursing since 1965 in various ways including tertiary education, nursing, management, and government legislation and policy development and review. This broad background enables her to research, publish and supervise doctoral and masters students across a full range of topics around health, education, ageing and aged care, safety and quality of health care, clinical outcomes and quality of life research, management, policy and workforce matters.

Internationally her involvement includes professional conferences and seminars including an address to the Shanghai International Symposia on caring for the elderly in 2006. She was also a member of the United Nations World Expert Groups on Ageing (2007) and Social Integration (2008). She was invited to Germany by the United Nations to participate in developing a draft convention on the rights of older persons (2009), and to Tunisia (2010) where she assisted in drafting recommendations that could provide a policy structure within which Arabic women might empower themselves. The World Health Organisation has appointed her to the Expert Research Review Panel with the World Alliance for Patient Safety and she is the elected Chair of the Royal College of Nursing Australia Faculty of Health and Wellbeing in Ageing.

Her professional goals are to ensure that issues affecting the practical environments of health professions are given prominence in policy and regulation development and review; and that individuals involved in all fields and contexts have access to educational and professional leadership that will support them to advance their careers in practical as well as theoretical fields of endeavour.

THE PATRICIA CHOMLEY MEMORIAL ORATION

Established in 1966, the Patricia Chomley Memorial Oration has become part of tradition at Royal College *of* Nursing, *Australia* and has been presented annually to honour Miss Patricia Chomley, the first director of RCNA.

Appointed in 1949, Miss Chomley was director until her retirement from the position in 1964.

During the 15 years of Miss Chomley's leadership, some six hundred students undertook courses. Many of those nurses subsequently held responsible positions throughout Australia and were instrumental in important developments in the nursing profession and in upgrading the quality of patient care.

Miss Chomley passed away on 24 October 2002 and the Patricia Chomley Memorial Oration is a fitting tribute to her leadership and contribution to RCNA.

PAST ORATORS

1966 Professor J A Ovenstone – Automation and its implications in Australia
1967 Dr Phillip Law – The changing pattern of requirements in professional education
1968 Professor R A Rodda – Pioneer nurses: Then and now
1969 Miss Patricia Church – After twenty years – A pause for reflection
1970 Reverend Mother Lois – The changing status of professional women
1971 Mrs Joanna Wilkinson – Introduction to the concept of the group care unit into professional nurse training
1972 Mr M H Bone – Lifelong learning: The role of permanent education in the education system
1973 Professor R M Mitchell – Nursing and modern medicine
1974 Miss Beatrice Salmon – Pragmatic axles turn on emptiness
1975 Sir Paul Hasluck – What is the use of history?
1976 Miss Patience R Thomas – The role of women over three centuries
1977 Professor David Madison – Coping with crisis: A challenge for the health profession
1978 Dr John R Sabine – A jug of wine, a loaf of bread and thou
1979 Mr James P Smith – Nursing needs a professional renaissance
1980 Miss Rosalie Pratt FRCNA – A time for every purpose...
1981 Dr Rosemary Crow – How nursing and the community can benefit from nursing research
1982 Miss Patricia V Slater FRCNA FCN (NSW) – The role of nursing organisations in professional education – Challenges for the future
1983 Miss Bartz Schultz FRCNA – Founders of the College
1984 Professor Baronees McFarlane of Llandaff – Nursing – Fit for the future?
1985 Lady Murray – Women of significance in Victoria's history
1986 Dr Sandra Stacy FRCNA – Nurses and other people
1987 Dr Margretta Styles – The challenge of excellence
1988 Ms Gillian Biscoe FRCNA – Thought, action readiness and responsibility
1989 Sister Veronica Brady PhD – Primary health care: The challenge for the health profession
1990 Ms Gracelyn Smallwood – Aboriginal health by the year 2000
1991 Miss Joan Godfrey OBE FRCNA FCN (NSW) – Nursing's heritage: Chains to loosen
1992 Professor B Hayes FRCNA – The voices of Australian nursing: A turning point for the twenty first century
1993 Ms Margaret Robinson FRCNA FCN (NSW) – Reflections of the past...promise of the future
1994 Hon Austin Asche AC QC – Family law and its effect on the family
1995 Associate Professor Sally Garratt FRCNA – Nursing and human service
1996 Dr Kathleen McCormick PhD FAAN FACMI– Guideposts for the 21st century
1997 Miss Merle Parkes AM FRCNA (DLF) – Transitions through time
1998 Emeritus Professor Margaret J Bennett FRCNA – The Humpty-Dumpty Syndrome: Obfuscation or clarification?
1999 The Hon. Justice Michael Kirby AC CMG – Nursing and the law – Maintaining human care in the whirlwind of technological change
2000 Reverend Tim Costello – Wholeness, healing and hirelings
2001 Dr Lowitja O'Donoghue AC CBE FRCNA (Hon) – Healing the wounds: nurses and reconciliation
2002 Sister Paulina Pilkington RSC AM PhD FRCNA (Hon) – Looking back into the future
2003 Ms Val Coughlin–West FRCNA FCN (NSW) – Leadership – Great Expectations
2004 Assoc Prof Joy Vickerstaff FRCNA FCN (NSW) – Leading from the Centre
2005 Adjunct Professor Debra Thoms FRCNA FCN (NSW) – Every Step a Challenge
2006 Professor Sandra Dunn FRCNA – Making a difference: how nurses influence patients, communities and healthcare systems
2007 Professor Jocalyn Lawler FRCNA – Nursing in interesting times: a reflection, an analysis and a reading
2008 Professor Sandra Legg FRCNA – Nursing: A Moderate Love
2009 Professor Anne McMurray AM FRCNA – Empowerment and enterprise: the political economy of nursing and midwifery
2010 Mr Jamie Ranse RN FRCNA – Inspiring, progressing and promoting the profession of nursing in disaster health

NURSING – OUR MULTIGENERATIONAL WORK IN PROGRESS

I am honoured to have been invited to deliver the 45th Patricia Chomley Oration in this place, and to this audience of distinguished nurses and honoured guests.

We nurses are part of something that stretches back centuries. Our social institution has a history of being central to all people, everywhere, in each stage of life and at all times. Very few professions can make such a claim.

Nursing is unique in the way we have always responded to society's requests of us, while also maintaining the passion and commitment each generation of nurses brings to the continued development, relevance and integrity of our work.

In the year I was born Patricia Chomley was appointed Director of the College of Nursing Australia and, for the next 15 years, she worked to provide nurses with an education that would advance their ability to provide Australia with safe and effective nursing care. I am blessed to have been involved with Australian nursing for 45 years now and much of what I have to tell you draws on a lifetime of getting involved, paying attention and taking a stand.

This evening I plan to share with you my insights into Australian nursing and why I consider nursing to be the backbone of health and social care in this country.

GENERATIONS

Each generation of nurses responds to the challenges and opportunities of their time. The choices past nurses have made, and compromises either accepted or rejected, shaped what nursing became during their time, and what was inherited by subsequent generations, leading to what we currently understand to be 'nursing'. It is sobering to realize that our choices and the strength of our commitment to nursing and its purpose, are already reshaping the nature of the profession we will hand on to the next generation of Australian nurses.

Across our history the insights, skills, courage and determination of contemporary nurses to build credibility and integrity and to concentrate their efforts on those for whom they care, has prevented nursing from being diverted to roles and functions that serve other disciplines and vested interests. Equally their efforts were pivotal in preventing the fragmentation of nursing through neglect, lack of focus, or exploitation of other nurses for personal gain. Service to the community, a fundamental tenet of professionalism, motivated our nursing ancestors to achieve astonishing outcomes for their patients, sometimes in dreadful circumstances and against intimidating opposition.

Throughout the 19th and 20th centuries issues with genuine consequences for nurses and nursing increased in complexity and subtlety. This trend continues and as the 21st century progresses, changes will emanate from sources not yet identified, as well as from sources that may go unnoticed, and from sources we never expected to be so important.

As each generation shapes nursing to fit time, place, society and technology, nurses remain faithful to the narrative handed down over many decades. Each generation carefully prepares the next generation to be aware, committed, willing and capable of taking up stewardship of our profession in the knowledge that they too will ensure that nurses who follow them are able to do the same.

I expect no less of my nursing colleagues.

FINDING THE NARRATIVE

Our nursing inheritance is entwined with a narrative that centralises the nursing care of others. It connects us through time with nurses who worked to preserve the reliability and significance of nursing over centuries. Where nursing began is difficult to pinpoint but we could say that a significant strand of the Australian nursing narrative started in England where a band of women worked to pursue justice and equity for those in need, as well as suffrage for themselves and other women.

19TH CENTURY BEGINNINGS

In pre 1800s England, nursing was part of any maternal role. Women provided care and support for the family as well as the poor and needy and later, women developed what we understand today as nursing care. Physically strong and reasonably sober men were also present in workhouse infirmaries in 1860s as 'keepers' and worked in sex-segregated areas (Mackintosh, 1997). However, nursing as a caring vocation developed by religious orders and Florence Nightingale's secular activity, was based on 'sisterhood' leaving no place for men.

At that time nursing was seen as a natural undertaking for women and most nurses tended to isolate themselves as far as possible from male workers in the infirmaries. Male attendants in asylums and workhouses rejected any attempts at take-over by 'lady' nurses. When they realised that they were at risk of being externally controlled because of their rowdy reputation, they began a register of 'good attendants for the insane' in 1879. But the truth is they were ill-prepared to resist incursions from these privileged, middle-class women who were sponsored by the patriarchy. Infirmaries and workhouses were soon dominated by lady nurses (Mackintosh, 1997). Much later in 1919, women's suffrage in Britain and the Nurses Registration Act (1919) created a single entry pathway to nursing. Male nurses were only allowed to register at level two. Considering these origins, the story of men in Australian nursing is interesting in terms of their current positional authority over nursing.

Nineteenth century women lived in a patriarchal society with few socially acceptable occupations other than motherhood or religious orders. Women with time and freedom were mostly wives of powerful men who allowed them to do 'good works'. It was these women with influential families and connections who embraced 'doing good' as their obligation to others and as a way of connecting more broadly with people outside their social echelon. Because doing good melds with

church values, they were able to move about the community helping others in need, especially those deemed worthy of their care.

Florence Nightingale was such a woman. Borne in Florence Italy in 1820 she lived most of her life in London with her ill-matched parents. Though unmarried, she used her family connections to raise awareness and marshal resources to help destitute and sick people in England (Holliday & Parker, 1997). She was politically astute and relentless in pursuit of her agenda so it is not surprising that her opinions frequently rang through the corridors of power. Her determination to build an option for middle-class women to be gainfully employed resulted in a system for training nurses who could then be dispatched anywhere Nightingale considered worthwhile. She designed nursing as a service that could be allocated to a range of problem situations and managed remotely from her rooms in London.

So it was that Sir Henry Parkes, Colonial Secretary of New South Wales, wrote to Nightingale requesting that she send some of her nurses to the colonies. Six Nightingale graduates led by Lucy Osburn, stepped off a ship in the convict outpost of Sydney Cove in March 1868…eighty years after the arrival of the first fleet.

Lachlan Macquarie had taken over from William Bligh as Governor of the colony. Bligh had tried to clean up widespread organised crime involving John Macarthur and military corruption associated with the rum trade, but had failed (Dando-Collins, 2007). Macquarie approached the problem differently and allowed these corrupt businessmen to control the importation and distribution of rum if they built a hospital. With meagre funding from this arrangement, the Sydney Infirmary was built at the location of the Sydney Dispensary which had provided some health services to the poor, and this later became Sydney Hospital (Pitkin, 1996).

Bethsheba Ghost was the first matron of Sydney Infirmary. She came to Sydney as a convict on the Planter to serve 14 years for receiving stolen goods. In England she had been a nursery maid and was one of the convicts in the colony appointed by Governor Bligh to positions of authority – a practice that contributed to his public vilification by John Macarthur and his cronies. Beth found it difficult to rise above her convict status and be accepted in a society dominated by male authority and their English class system. She was shabbily treated along with most nurses of the time who were automatically considered to be dirty, callous, uncaring slatterns and probably alcoholics. However from 1852 until she died in 1866 she worked under difficult circumstances to improve nursing care and provide basic training for nurses in an organisation where the board of management and infirmary staff subverted the rules for their own gain (Godden, 2004).

Lucy Osburn arrived two years later and for 16 years, the infirmary was to be her home and workplace. After Beth departed and before Lucy's arrival the board and doctors appointed a male superintendant to ensure she would have no authority and they would not have to deal directly with her. No proper accommodation had been arranged and she and the other nurses were told to stay in dilapidated rooms next to the filthy, rat-infested, stinking, infirmary (Pitkin, 1996:32).

She had a choice: to stay where she was clearly not welcome, or to get back on the ship and return to England. At 26 years of age she must have felt a long way from home.

Lucy stayed. She threw herself into the work of helping patients in this Dickensian hell-hole. The colony too was plagued by dreadful conditions and society was tainted by widespread lack of respect, abuses of power, corruption and prejudice. For the next 5 years she maintained her standards and led her group of 'sisters' despite resentment and opposition from those in power. The medical superintendant, Sir Alfred Roberts, even travelled to England where he maligned her methods and approaches to Nightingale, turning her against Osburn (Pitkin, 1996). Sir Henry Parkes sprang to Lucy's defence but the damage to her reputation was done.

In 1873 a Royal Commission was authorized to examine the conditions of the Sydney Infirmary and investigate Lucy Osburn's activities. The commissioners were appalled at the procrastination, delays and deliberate slowness by the board of directors and the House Committee in responding to Osburn's many requests for improvements and change. She was exonerated and appointed Matron. The superintendant position was removed. (Pitkin, 1996:32) Later when Nightingale directed her to return to England she declined. I could find no record of how politely she expressed this.

Other women around that time had also been actively setting up care services in the colony (Brodsky, 1968). The Sisters of Charity who had arrived from Dublin in 1838 were providing community care for the poor in Parramatta. They later established St Vincent's Hospital in 1857.

Florence Abbott trained at Sydney Infirmary with Lucy Osburn and at age 26, moved to Tasmania to reform the hospital system which had been staffed by convict women and untrained wardsmen. Her trained nurses were sought after by other state hospitals including Prince Alfred in Sydney.

Caroline Chisholm had been working to help emigrant women in the colony who were being exploited and abused in this very tough town. She set up hostels, health clinics and an employment registration system for women and facilitated their travel to rural areas where they found decent work. It is possible to think of her as the first primary health care nurse in Australia.

Ellen Julia Gould (Nellie) trained at Prince Alfred Hospital and became matron of Sydney Hospital 1891-1898, then the Rydalmere Hospital for the Insane 1989-1900 and then the St Kilda Private Hospital at Woolloomooloo, the first private hospital in NSW. In 1914 she was appointed matron of No.2 General Hospital and sailed to Alexandria to provide nursing care to Gallipoli casualties.

Christense Sorensen borne in Sandgate, Brisbane also served on hospital ships during the Gallipoli campaign and in Egypt. She became general matron of the South Coast Hospitals Board from 1928.

Sydney Home Nursing Association appointed Amy Mann in 1899 as the first nurse to provide help to sick and poor in their own homes.

Trained nurses from Sydney Hospital and elsewhere took nursing services to all parts of Australia, responding to the needs of society and their communities. They also took with them a key part of the Australian nursing character, that is, social awareness, courage, hard work and determination to ensure patients are well cared for.

There are many stories that paint a compelling picture of nurses who persisted in the face of adversity as well as struggling with internal and external pressures to conform to standardized approaches to care. All of them realized that while nursing had been set up to parallel the medical focus on disease, if nurses were to establish nursing as a unique service with social relevance distinct from medicine, a major effort was needed and they were prepared to take it up.

> *The unifying nursing narrative throughout the 19th century was about 'care' and the 'power and authority to provide nursing care'. In order to be in a position to provide nursing support for the disadvantaged, nurses required skills and determination to present their services in a way that resonated with the people who needed their help, and organised in such a way that secured the resources needed for effective nursing outcomes to be achieved in difficult situations.*

20TH CENTURY DEVELOPMENT

The 20th century was a period of dramatic changes to every facet of Australian life. When World War I started in 1914 many nurses enlisted in the Australian Army Nursing Service. Elizabeth Kenny served for four years on sea transport ships and later worked as a bush nurse in Queensland. It was here she came across infantile paralysis. She developed a non-medical treatment for poliomyelitis which caused the medical profession to rise up against her, claiming that she was exceeding what a nurse should be doing. Several epidemics in Australia confirmed the value of her treatment as her clinics provided the only real hope of recovery for thousands of children with this disease. Her clinics were also set up in America where, as a mark of appreciation from that government, she was allowed to enter and leave freely without showing her passport or papers (Brodsky, 1968).

The early part of the 20th century abounded with nurses motivated to respond to need by ensuring that they had both the appropriate training and control over the means of delivering nursing services. Their practice development was focused on practical research and innovation to improve intervention and care effectiveness. Many nurses at this time achieved impressive care outcomes and set up systems that ensured patients received safe and effective care. There are too many valiant women in 20th century nursing to mention tonight, however any omissions should not be seen as my denigration of their contributions to Australian nursing.

Muriel Doherty commenced training in 1916 at Royal Prince Alfred and, ironically, in 1925 received the Alfred Roberts Medal for General Proficiency… yes, a nursing medal commemorating the same doctor who tried to destroy Lucy Osburn's work and reputation.

Muriel travelled to England and studied at London University, graduating in 1933 as a 'sister tutor' after which she returned to Sydney to set up the Preliminary Training School at the Prince Alfred Hospital. When WW II was declared she was the first reservist to be called up for service and was soon asked to inaugurate the RAAF (Royal Australian Air Force) Nursing Service in NSW, followed by a rapid climb up the ranks to be Matron-in-Chief, Melbourne HQ. After the war, in 1945, she joined the UN Relief and Rehabilitation Administration and was appointed Principal Matron in Charge of Belsen exNazi Concentration Camp. King George VI acknowledged her services to the RAAF with the Royal Red Cross. In 1946 she was appointed to the United Nations Relief and Rehabilitation Administration Mission to Poland to assist rehabilitation of their nursing education services. On her return to Australia she founded the NSW College of Nursing.

Doherty's textbook for nurses Modern Practical Nursing Procedures, written in 1963 in collaboration with Ring and Serl, was based on what she observed of modern care of older people during her time in Europe. My copy of Matron Doherty's 'nursing bible' has pride of place on my bookshelf.

World War II involved many Australian nurses at home and in theatres of war. Vivian Bulwinkel had trained at Broken Hill Hospital and enlisted in the Australian Army Nursing Service when war was declared in the Pacific. When Singapore fell to the Japanese, she escaped in the Vyner Broke, a ship filled with women and children and 65 nurses. The ship was bombed near the coast of Sumatra, many drowned and some were captured by the Japanese soldiers. Twenty two nurses including Vivian were surrounded on the beach, forced into the shallow bay and massacred by machine gun fire. Vivian was wounded and managed to escape but was eventually captured. As a prisoner she provided care and leadership to other captives until the end of the war.

You may not realise but during the 1940's war years efforts were being made by the Royal Melbourne Hospital and the University of Melbourne to establish a university qualification for nursing. Internationally nurses were being educated at tertiary level and Australian nursing needed to catch up. While the Melbourne effort was unsuccessful it shows the forward thinking of nurses at that time.

During the 1950s the international focus of nursing was on mechanistic theories and empiricism. The emphasis was on defining the nurse patient relationship and international theorists such as Henderson, Orlando and Peplau examined in detail what nursing and caring was all about (Marriner, 1986).

Australian nurses returning from war service saw the benefit of organising nurses as a force within the health services environment and began developing administrative roles, organisational systems and a chain of command in nursing that could deliver the resources and support nurses needed to deliver care. Major hospitals across Australia were structured with administrative, nursing and medical

hierarchies under the chief administrator, matron and medical superintendant who formed the executive team. Each was responsible for the efficient running of their services within the hospital. The hierarchical nature of the arrangement meant that issues arising at any point in the system could decisively be resolved. At all levels of each pyramid there was oversight and accountability as well as a clear succession pathway.

I first engaged with nursing in the mid 1960s when my father decided I would be a nurse. He was a navy clearance diver and had been impressed by the nurses who cared for his shrapnel wounds during WW II. So, I commenced my four-year training program to become a nurse. During that time the Prince Henry Hospital course was reduced to three years so I ended up doing three and a half years of training.

The nurses who trained me were both tough and kind; understanding and intolerant of weakness; but at all times confident in their shared purpose which was to provide safe and effective nursing care to people who needed it; and to make sure that anyone wanting to be a nurse had 'what it took' to do it well. Predictably the attrition rate for pupil nurses was very high with only 30% of my group actually finishing their training.

These nursing sisters, all women, were defined by the profession to which they were totally dedicated and for which they were willing to sacrifice much. They were not doing it for the money or self-aggrandisement although their expert power as nurses made them seem quite formidable. Patients came first and they did not hesitate to despatch anyone who obstructed their work, distracted their students, or jeopardised patient care.

> *The narrative of the first half of the 20th century built upon previous generations with nursing care retained as the central theme. Managers and educators, although secondary to the process of nursing, were expected to support 'nursing care' that is informed, proficient, reliable and accountable. The strong message that nursing is not something everyone can learn to do well, and those not able to meet exacting standards of physical health, moral strength, emotional resilience and intellectual ability were encouraged to seek alternative careers so as to prevent risks to patients and other nurses.*

In the late 1960s the World Health Organisation severely criticised hospital training for nurses (Chittick, 1968) and in the early 1970s the International Labour Organisation (1973) and the World Health Organisation criticised the prevailing conditions of work and life of nursing personnel world wide.

As a trained nurse in 1970s Australia we again faced war. Our brothers and boy friends at age 18 were being conscripted to fight beside the Americans in Viet Nam despite not being old enough to vote. When the army recruiters came to the hospital, I signed up for service but the war ended before I was called. My boyfriend at the time was horrified that I had done this when he was trying to avoid conscription.

The injustice of conscription, plus our commitment to support those who did go to Viet Nam, caused a social and political awakening within my generation. Australian society began to stir from post WW II complacency and we began to call into question the decisions of our government and politicians who obsequiously followed other nations' political agendas.

Australia's social awakening was accelerated by the Women's Liberation movement which strove to make women's private miseries caused by sex discrimination, a matter of public concern. In universities, feminist theories and ideologies were being developed and debated in the public arena. Social researchers delighted in studying nurses as the epitome of an oppressed group of women dominated by medicine and bureaucracy (mostly male). For my part, I didn't think nurses were oppressed …politically naive maybe. My experience is that nurses were held in high regard. The Whitlam government had given us free access to tertiary level education through scholarships. We had control over our own practice and systems of service delivery and could move and find nursing employment anywhere including internationally if we wanted.

> *The narrative at this time was strongly emancipatory even though nursing care remained central to our purpose. We realised the need to build a nursing power base that could be used to benefit disadvantaged people and those in need of nursing care, and we were determined to learn how to access and use it.*

Discussions concerning power at that time usually revolved around the French and Raven typology of social power which distinguished five types: referent power, expert power, legitimate power, reward power and coercive power (French and Raven, 1959). Although fifty years old, these sources of power still provide useful insights and understandings around how nursing in Australia has adapted to different circumstances. Nursing expert power had been well established from the mid 1800s and many of us realised that with the addition of legitimate power, which attaches to organisational positions rather than people, nursing power could be enhanced. Authoritarian use of rewards and coercion to manipulate people had no place in nursing – or so we thought at the time. Referent power was not a key source of power although some nurses pursued close links with medicine, law, sociology and other influential disciplines in order to access personal power. Many were absorbed into these alternative careers and professions possibly diminishing nursing's influence rather than enhancing it.

In the late 1970s I worked at St Vincent's Hospital with Sr. Paulina Pilkington who was the Commonwealth Nursing Officer at that time. I became aware of the committee she was working with to deliver the Sax Report (1978) which is arguably the most significant review of nursing and nurse education in Australia. This report stripped bare nurse education and training in hospitals and

identified its inadequacies. The report urged that nurses be given access to tertiary education as a matter of urgency.

Spurred on by the Sax report and the women's movement, Australian nurses began to throw off the shackles of traditional hospital roles and began lobbying for and moving into more diverse areas of nursing practice that were not dependent on medical delegation or direction.

It was in1984, just before a tightly run election, when NSW Premier Neville Wran announced that, within a year, nurses would move into colleges of advanced education (CAE) and that an undergraduate diploma in applied sciences would be the pre-registration requirement for registered nurses.

While nursing had recommended a four-year degree level pre-registration qualification, we took the pragmatic decision to accept the three-year diploma offer and rushed to set up the CAE courses. Experienced hospital educators were hired by CAEs to quickly write curricula and content for teaching and get the courses accredited within 6 months of the announcement. Most had no tertiary qualifications however it was anticipated that once the courses were up and running, time and support would be available for them to pursue their own qualifications.

A shortage of Australian nurses with higher degrees meant having to go along with the pragmatic option of offering leadership positions to people more qualified in other disciplines than in nursing. Many who were enticed back had left nursing many years before to pursue other disciplines and occupations. Immigrant nurse scholars from countries where the nursing history and culture differs from Australian culture or practice were also attracted by offers of professorships and senior university management roles.

The impact of this influx of people to powerful positions, despite being unfamiliar with Australian nursing, has not been researched in terms of its effect on models of practice, nurse education and health care system development during this period of rapid change. Anecdotally we see the natural inclination of nurses from other countries to duplicate familiar systems and cultural practices and through their appointment to leadership roles they were in a position to implement such changes. At this point I should also acknowledge men as a privileged minority in nursing compared with their female colleagues.

In Australia as elsewhere, men are fostered in their career advancement by female nurses, often to their own detriment (Evans, 1997). As a result men as a minority group occupy a disproportionate number of administrative and elite speciality roles in management, clinical and academic nursing. No logical comparison can be made between men in nursing and women as a minority group in male dominated occupations such as the defence force where women are systematically disadvantaged and exploited because of their sex. Current nursing systems work well for our powerful male minority group and I have observed that they tend to be counter-revolutionary in a system that promotes their prestige and career prospects over that of women. It will be interesting to see if men in nurse leadership positions alter the culture as Evans (1997) suggests, by asserting their masculine selves and diminishing nursing's quintessential feminine role and historical identity. I am not saying this has happened, however we need to be alert to the possibility and consider the impact on women in nursing and the future attraction of women to nursing careers.

BECOMING AN ACADEMIC DISCIPLINE

Over the 1980s tertiary institutions gradually replaced hospital-based schools of nursing, and then CAEs began to convert to full university status. During this period I was a lecturer on short contract at the University of Wollongong. We were faced with four major issues that had to be resolved in relation to university-based nurse education: (1) identifying the essential qualities of nursing education; (2) designing curricula for content rather than the process used in hospital-based courses; (3) finding ways to transition hospital-based educators into academia; and (4) negotiating and building relationships with other disciplines, especially medicine and the disciplines of those leading nursing, that recognised nursing as an academic discipline.

Much was said and written in this period about the work of academics and administrators in vying for health system power and tertiary sector acceptance by established academic disciplines. Nursing hierarchies had been dismantled within the public health system leaving only administration and medicine with positional authority and power. Matrons were no longer fashionable and the role devolved into a range of smaller generic responsibilities that may or may not require nursing qualifications as 'nurse' was phased out of nurse management titles. In some hospitals nurses were allocated to medical speciality units and answerable to medical directors who defined the roles they were to undertake within the unit. The most common mentions of nursing came from administrators claiming that the supply of nurses was inadequate; and from academics rationalising the clinical learning component of pre-registration courses and commodifying education offerings; and from trade unions struggling for relevance as union membership continued to decline. Accounts of nurses and their work to provide nursing care to those in need are eclipsed in the literature and media by the din of academics, administrators and trade unions promoting their own agendas.

> *In this period of educational change and health service upheaval the Australian nursing narrative becomes difficult to locate. I have no doubt that nurses continued to provide nursing care in hospitals, aged care, disability services and the community even though the work they were doing was relatively hidden. The 'nursing problem' was spoken about by others but nursing voices were muted.*

Some new role options for nurses opened up in 1985 when the first evaluation of the 1977 WHO (World Health Organisation) social target of 'Health for all by the year 2000' occurred (WHO, 1998). Possibilities for employment outside hospitals included primary health care, health education, health promotion and disease prevention to name a few. Australia along with most countries was

progressing on the WHO global indicators and showed strong political commitment to developing good social policy and strategies to deliver health programs. The emphasis for nurses who embraced these opportunities was on holistic care and family nursing where nurses are familiar with the health needs of their patients and work collaboratively with them to achieve health outcomes. There were also greater roles for nurses in policy-making, management and quality benchmarking of nursing care as well as a move towards a refinement of international nursing theory to incorporate these new developments.

Whether or not all newly developed CAE curriculums successfully incorporated these new opportunities is unknown. I remember the battles I went through to have community nursing, aged care and primary care (a precursor to nurse practitioner role) included in the senior year curriculum rather than in first semester. The haste with which courses were written, and the political imperative of establishing nursing's legitimacy within tertiary education and marketing nursing qualifications to other countries, in many ways, mitigated against including contemporary Australian issues in the preparation of the next generation of nurses.

The emphasis for academics involved with nursing was on developing research methodologies that had relevance to practice issues and the development of cognitive skills. Considerable work was also needed to get nurses to agree on domain concepts and boundaries that would build a nursing paradigm. Performance in this area was seen as crucial to the acceptance of nursing as a unique discipline by the scientific community and academics took up the challenge.

BECOMING A CLEVER COUNTRY

Australian nursing was the first academic discipline to develop and implement competency standards for clinical practice. Overseas nurses' clinical competence was assessed to guarantee safety of patients if they were to register in Australia through the Nursing Competencies Assessment Project (NCAP) which had started in 1986 to deal with nurses' competencies in hospital nursing roles and contexts (Butler, 1990). Also in 1986 the Health Department and TAFE NSW commenced an enrolled nurse certificate course. Previously, enrolled nurse courses had been run by hospitals and nursing home schools.

The Hawke Labor government in 1989 stopped free tertiary education and set up the Higher Education Contribution System (HECS) which included a system of deferred HECS payments to encourage people to take up university education. We were all worried that there would be a shortage of nursing students if they had to pay for access to university education.

With all of this activity, it is not surprising that nurse administrators and academics remained unaware as one of the greatest changes to the environment in which Australian nursing had operated, was quietly and irrevocably installed in 1989.

Prime Minister Hawke in 1990 achieved consensus agreement with the state governments to work towards Australia becoming the 'clever country'. A National Training Board (NTB) was set up and occupational groups were allocated to different training boards which would develop 'on the job' training packages leading to nationally accredited qualifications under the Australian Qualifications Framework (AQF) in1995. Aged care was allocated to Community Services and Health (CS&H) and occupations in aged care were defined as 'care work'. Those employed to do it were categorised as 'care workers'. In 1991, TAFE NSW commenced the Enrolled Nurse Advanced Certificate IV which was recognised only in NSW and not under the AQF.

The transition of state-funded, tertiary sector nurse education to commonwealth funding was completed by 1993 when degree level pre-registration courses commenced. The Australian Nursing Council (ANC) had been set up in 1992 to provide a national approach for nurse registration and built onto the work commenced in 1991 to establish competency assessment of overseas nurses through the ANRAC competencies. ANRAC also guided CAE curriculum developments for nurses and, in 1993, this work was further developed by the ANC into the 1993 ANCI competencies for registered and enrolled nurses.

The Community Services and Health Industry Training Advisory Board (CS&H ITAB) released the Certificate III for the Assistants in Nursing (AIN) and Personal Care Attendants (PCA) category of worker in the aged care industry. Hospital and TAFE nurse educators turned consultants had worked on both of these nationally recognised qualifications and the content of both reflected the interchangeable nature of the work they do. Industrially, variation between state jurisdictions as to trade union coverage of care workers and assistants in nursing, led to further confusion. Some registered nurse organisations refused to acknowledge these nationally regulated and accredited AINs and PCAs as part of nursing even though they perform nursing work as directed by RNs and report in many instances to ENs and RNs.

HIDDEN FRACTURES REVEALED

After being in operation for only a few years, nursing underwent a National Review of Nurse Education in the Higher Education Sector in 1994. The government review was set up in response to lobbying by medical, hospital administration and some nursing organisations critical of new CAE graduates' ability to perform satisfactorily in hospitals. Review findings were very critical of teaching practice and learning outcomes. Considerable weight was given to the lack of qualified educators involved. Apparently many nurse teachers who had effected the transfer to tertiary education had not received sufficient support or time to upgrade their qualifications as promised in the early 1980s.

The situation faced by new graduates in the public hospital system was equally distressing. They were not welcomed by established nurses and administrators in medical treatment units. Few hospitals provided educational support so clinical placements which were expected to be cost-neutral began to cost universities in terms of providing clinical teachers to go on placement with

students. Some hospital directors of nursing even proposed charging universities an access fee for clinical placements. Many specialised clinical areas were deemed 'off limits' to students as registered nurses refused to take on added work and responsibility of students in their work areas. New graduates who found employment faced direct competition from nurses who had graduated a few years earlier, for access to professional development opportunities, attractive shifts and information generally. Several years of new graduate attrition within the first year of being a registered nurse led to a significant nursing shortage, first in hospitals and then across other areas of nursing practise. Managers collaborated with trade union officials to adjust models of nursing and workloads to lower the acceptable level of registered nurse participation. The shortage was thereby normalised in the early 1990s and most likely will never again expand to levels experienced in decades past, despite media rhetoric around nursing workloads.

The university sector in 1995-96 underwent restructuring in terms of funding with huge cuts by the Howard government forcing greater focus on attracting research funding and overseas full-fee-paying students. Part of the restructure included setting up a three tiered Higher Education Contribution (HECS) scheme to acknowledge that some professions would be able to earn more on graduation. Nursing was placed at the lower end of that scale.

Perhaps because of the flurry of university restructuring, and pessimistic reviews of nurse education, as well as pressures from clinical nurses and hospital administrators about new graduate 'job-fitness', few noticed in 1995 when the Australian Qualifications Framework was implemented by the Vocational Education and Training Advisory board (VETAB). In this framework all qualifications and work roles could be mapped against seven levels on the national grid where assistants in nursing were at level 3; enrolled nurses at Level 4 or 5 if a diploma; registered nurse equivalent work came in at level 7. The medical profession succeeded in avoiding being mapped – but nursing work was locked in at several levels.

By 1999 Cert III and IV in Aged Care Work was available as a national qualification that could substitute for AINs and ENs in aged care and could work free of constraints imposed by nurse registration on enrolled nurse scope of practice. Maybe because they realised what had occurred, nurse educators in TAFE began to resist placing EN Advanced Cert IV under the AQF, preferring it to remain a state qualification under nursing control. In 2001 pressure from a large not-for-profit organisation in aged care to replace enrolled nurses with qualified aged care workers resulted in a Review of the Role of Enrolled Nurses in Aged Care. I was a member of the review panel and fought to retain a role for ENs in aged care despite management arguments that EN employability was reduced by mandated registered nurse dominance of their practice (Commonwealth Department of Aged Care, 2001).

It was beginning to dawn on Australian nurses that circumstances had changed. For the first time in nursing's history they, and the work they do, could be replaced by some other category of worker.

And not just any worker. These new occupational qualifications were mostly designed and written by nurse consultants, employers (including nurse managers) and trade union officials. They are accredited nationally and based on competency assessment as well as providing flexible education pathways for everyone who wants to build their employability. Work traditionally performed by nurses in operating theatres, audiometry, management, geriatrics, counselling – the list goes on – could now be developed into a training package and delivered by registered training organisations (RTOs) who purchase the package from VETAB.

The significance for nurses is that 'care work' emerged as a non-nursing occupation, fracturing 'nursing' from 'care'. 'Nursing care' is a term disappearing from the nursing lexicon as we acknowledge that nurses, especially in hospitals, increasingly perform delegated technical tasks rather than nursing care; and that nurses in aged care increasingly take up management and clinical leadership roles leaving care work to be performed by care workers. If nurses in acute care contexts distance themselves from nursing care responsibilities, and there is evidence that this is happening (McDonald, 2007), nationally accredited courses in Acute Care Work up to level seven can be designed and implemented within a year if managers undertake to employ them.

> *The narrative of nursing over the 1990s was overridden by an escalating culture of managerialism that promoted administrative and regulatory compliance responsibilities over nurse management focus on ensuring safe and effective nursing care environments. In universities the undergraduate nurse programs adopted standardised generic content to achieve economies of scale; while student access to credible nursing role-models and clinical learning opportunities were reduced as clinical nurse teacher positions were casualied.*

It is no wonder that nurses at that time wondered about their continued relevance and value in a competitive employment environment that is increasingly medico-centric. The growing disconnection between education and management, and between both of these and clinical nursing encouraged many experienced nurses to take early retirement or pursue some other work. Consequently new graduates were left to struggle with their own concepts of professionalism while coming to terms with nursing identity and purpose.

Depending on where graduate nurses find employment, their nursing identity is shaped by their workplaces. For the lucky ones, access to experienced professional nurses who know who they are, and what they are there to do for patients, has provided them with the knowledge and skills to become nurses. Others may be diverted into administrative work or onto management or medical projects that are only loosely linked to nursing and it is possible that they will gradually lose connection with their professional purpose. It can happen very easily. It happened to me several times.

My strategy for determining if I am 'doing nursing' or not draws on my own definition of nursing developed after years of being distracted by invitations to be involved in 'interesting' projects and work roles:

> **Nursing** is the application of contemporary knowledge and skills to help people to respond in healthy ways to the situations they are in or are facing. Nurses manage the environments in which nursing occurs to maximise the benefits of nursing care for those receiving nursing help.
>
> **Nurse education** facilitates the development of knowledge, attributes and skills needed to provide safe and effective nursing care; to collaborate effectively with other professions and stakeholders to ensure nursing is appropriate and effective; and to understand the history and philosophy of nursing and the frameworks within which nursing operates to ensure professional accountability to society.

These definitions of nursing have guided me when approached to participate in medical research of uncertain relevance to nursing; or when offered administrative roles with no authority to defend staffing or resourcing of nursing services; or opportunities to progress through the academic career ladder by accepting university management roles sweetened with academic titles attached. While often enticing at a personal level, these positions do lie outside nursing and therefore those with nursing qualifications in these positions should not be automatically endorsed by us as representatives of our profession.

THE 21ST CENTURY DAWNS ON AN AGEING AUSTRALIA

Further changes have impacted on nursing in Australia since 2000. Regulations changed in NSW to permit RTOs to run EN traineeships were tested in 2001 when an aged care RTO submitted an application to run an EN course to boost the supply of ENs for aged care. It was twice rejected by the NSW Nurse Registration Board (NRB) leaving TAFE NSW as the only supplier of enrolled nurse training yet only hospital employees could access it. Clearly, the growing shortage of nurses in the aged care industry was not considered relevant to the public hospital system even though more and more residents were being transferred to hospitals as a result.

The first commonwealth government Intergenerational Report of 2002 identified a need to prepare for an ageing population and to build the aged care workforce and services more appropriate to older people's needs. Also in 2002 the Senate Inquiry into Nursing (2002) highlighted recruitment and retention strategies as a national planning priority; as well as improvements to the interface between health services and the education of nurses. Aged Care was identified as the area of services most in crisis because of the administrative burden on commonwealth funded registered nurses and pay inequity with nurses employed in state health systems. Also recommended was the establishment of a Commonwealth Chief Nurse position.

The deteriorating availability of registered and enrolled nurses for aged care employment reached crisis point and after much lobbying by peak aged care employer organisations, the National Review of Nursing and Nursing Education was set up and led by Patricia Heath RCNA (Hon). The report Our Duty of Care was delivered in 2002 and while it referenced nursing, the major focus of the review was an effort by managers to frame nursing in terms of relevant skills to their service needs, cost-effective models of staffing, and supply of workers. While implementation of different models of staffing commenced in the public hospital system in 2003, beneficial effects of the review are yet to be seen in the aged care industry. Some changes have occurred with the Certificate IV in Aged Care work now including medication administration; and NSW NRB changes to the EN scope of practice to include medication administration under certain circumstances.

Of all the outcomes of the Our Duty of Care Report, Recommendation 21 has generated most change. It asked for national consistency to be brought to EN qualifications and the incorporation of the EN Cert IV into the Australian National Training Framework. Two years later in 2004, the CS&H Industry Skills Council undertook the EN and Health Training Package (HTP) review (National skills Council, 2002). The Australian Nursing Council (ANC) and RCNA Enrolled Nursing Roundtable was convened to discuss EN in HTP. I took part in the deliberations regarding a proposal to include EN competencies in the Health Training Package under AQF, resulting in national consistency for EN qualifications. Consensus was reached that this was a worthwhile development for nursing and all except NSW TAFE and NSW Health proceeded to engage with the review. They insisted on limiting the qualification to a Cert IV even though the course content was close to that of UG Diplomas in other states.

Persistent doubts expressed by aged care employer organisations about the focus and quality of bachelor of nursing programs prompted the Australian University Teaching Committee (AUTC) to undertake a scoping consultation in 2004 (AUTC, 2004). The consultants examined bachelor of nursing (BN) curricula and the aged care expertise of nurse academics teaching the BN. They found a lack of best practice in curriculum design, teaching, learning and assessment. The causes relate to excessive teaching workloads, multiple teaching and assessment modes, deficits in individual learning styles, poorly planned clinical placements with unclear learning goals. The theory-practice gap had been accentuated by disconnection between out-of-date academics and uncooperative clinical nurses plus a lack of support for students on placement and casualisation of clinical teachers. Most notably the consultants were not able to identify discrete streams of nursing studies in national priority areas such as aged care even though funding for 400 additional undergraduate aged care places in the Bachelor of Nursing program were included in the 04-05 budget with forward increases to 1,094 extra places over 4 years.

Care of older people occurs in all nursing contexts and the fact that they are older is why they need access to effective health maintenance, preventive care and treatment. Clinician attitudes towards older people accessing hospital services are a matter of nursing concern. In a national study in

2007 I found that too many registered nurses in hospitals across Australia no longer consider basic care, nutrition, hydration, skin integrity, hygiene, comfort and even safety of patients to be their responsibility (McDonald, 2007). When asked why, several said that their workload was so heavy they could no longer provide basic care. If true, this represents a failure of nurse management in ensuring that nurses have sufficient resources and time to perform nursing care. It also indicates inadequate educational preparation of these nurses in terms of being able to identify issues affecting their nursing performance and having the ability and confidence to advocate effectively regarding a situation that poses serious risks to their patients.

University deregulation of fees and limits on student intakes occurred in 2005. The HECS became Commonwealth Supported Places (CSP) allowing students a maximum of 7 years full time to complete their studies. In 2011 limits on student places may be lifted completely with funding of individual students who will choose where to study. These changes could lead to more realistically funded undergraduate nursing courses. The test for academic managers responsible for nursing programs is to ensure that this increased funding for nursing is not diverted by university administrators to support other disciplines with fewer students. Long-term over-enrolment of students in nursing programs has left nurse educators with little time to complete their own qualifications while also having to deal with relentless demands of struggling international students. Funding changes in 2011 could herald some relief for nurse academics who have seen their workloads increase and their status in universities reduced because their participation in research projects or scholarly activities is simply not feasible under current conditions.

The significant role nursing plays in providing an effective health care system was acknowledged in June 2008 with the appointment of Rosemary Bryant to the position of Chief Nurse, Australia. While the position is primarily set up to advise the government on nursing and health matters, the opportunity to better inform those who formulate policy and control funding about the pivotal contribution made by nurses to public health is very welcome.

RESURGENCE OF NURSING LEADERS AND ROLE MODELS

We now have nurse practitioners (NP) in our midst and it is important that these nurses not be subverted into administrative or academic roles. It is crucial also that nurse practitioners are supported by other registered nurses in providing nursing care to those in need.

In Australia, nurse practitioners mainly operate in the public health/acute care sector. Latest information suggests that there are around 500 nurses qualified as nurse practitioners and around 400 employed in the public hospital system (Roxon, 2010). A test of nurse manager competence will be whether funding is made available to set up nurse practitioners with systems of support for their services which also need to be promoted and acknowledged. A further test of nurse management competence will be whether nurses and other professionals are willing to refer patients to nurse practitioners or whether nurse practitioners will be left to work with under-resourced, poorly organised arrangements and located in badly managed environments that undermine their ability to provide the level of nursing care they are trained to deliver.

Changes to legislation for the Medicare Benefits Schedule (MBS) services and Pharmaceutical Benefits Schedule (PBS) subsidised medicines schemes came into effect on 1 November 2010 enabling NPs to prescribe certain medications within their scope of practice. They are required through legislation to collaborate with medical practitioners and work under oversight from various government committees concerning pharmaceutical benefits as well as a Nurse Practitioner Technical Advisory Group with medical, management and trade union representation along with the Royal College of Nursing Australia and the Australian Nursing and Midwifery Council. These management, industrial and political oversight arrangements are not automatically supportive to nurse practitioners. Every aspect of their practice is placed under far more scrutiny than applies to physicians, managers or unionists. If professional support is to be available for this band of nurses, it will have to come from nurses themselves, ideally through the professional nursing colleges and from nurses within employing organisations.

If aged care were to set up and fund nurse practitioner positions, nurse practitioners would be required to provide services above and beyond the registered nurse roles of initial and ongoing assessment, planning and management of care and delivering the range of nursing services mandated under existing Specified Care and Services. Commonwealth funding of aged care does not allow for employment of nurse practitioners so, getting this into place will be a test of the competence of nurse managers and academics involved in policy review and whether nurse practitioners themselves will have opportunities to provide input on matters that directly affect their ability to practice nursing at this level

Nurses in every practice context are providing nursing care to people who rely on them to be sensitive, insightful, proficient, truthful and wise. Nurses bridge the gaps between the fears people have about their situations and how they might respond. Not a task for the faint hearted when working within a health system juggernaught that prioritises administrative and medical tasks over nursing care. It takes courage and sometimes daring to insist on nursing care being given when routines and administrative reporting systems place demands on nurses' time and energies.

The search for nursing role-models needs to be undertaken by each nurse. Think about the people who have inspired you to become a nurse and to continue the tradition of care handed down over centuries. Academics, bureaucrats, trade union bosses and managers are not necessarily best placed to provide guidance and mentorship in other than their fields of interest. We must be alert when those claiming to represent nurses interpret what they believe are issues and stipulate we respond in the way they direct. Many of these people have stood on the shoulders of nurses in order to move into other careers and professional fields and they may no longer retain legitimate links with nursing. Legitimacy would apply only when they use their positions and influence to benefit nurses or to

ensure that adequate resources and enabling systems are in place to support nurses in the delivery of safe and effective nursing care.

For me the search begins by identifying nurses with the motivation to help people in need and to apply a wealth of knowledge about people, society, science and practical strategies to their situations, so that their patients can make informed and supported decisions about the options available. Nurses with this motivation will stand out from the throng. They will also have a desire to assist other nurses to explore and develop their practice.

Nurse leaders such as the women I mentioned at the start of this presentation, form a relatively silent but potentially powerful force within the various systems of today's health care, management and education. It is up to each of us to find and learn from them about contemporary nursing and how we are shaping it for the next generation. It would be great if such leaders could be given opportunities to share their stories and insights about nursing and the vision for nursing's future that they want to achieve. The Royal College of Nursing Australia has taken up that challenge but we also need to support our college by staying connected.

My message to nurses assembled here tonight is fairly direct. Look to each other for leadership and don't be fooled by the glamour of prestige and pomp. Recognise each other for the value of what nurses do for people because even if those in positions of authority over us don't really understand it, the general public does. They know how they benefit from nursing care, support and protection. They realise that having competent, connected nurses in their communities brings balance … and they love us for it.

The nursing power base depends on our nursing expertise and ongoing public support. If we maintain our integrity and a direct relationship with the public rather than through spokespeople with vested interests, we can reinforce that valuable link. Your expressions of concern about the welfare of your patients and the systems of nursing care needed to deliver nursing services are desperately needed. Nurses, as individual nurses with concern for the public good, can utilise professional nursing colleges but also the media, your own blogs and in forums, debates and through feedback to government on their policies.

CONCLUSION

Will the next generation of nurses thank us for what we have done to our multi-generational work in progress? The 21st century is a decade old and we need to think about the profession we are shaping with our actions or inactions. The centuries-old narrative of nursing integrity and care for the disadvantaged in our societies has recently been overshadowed by a culture of managerialism and sustained attacks on our epistemological heritage through the commodification of nursing education. But I am convinced 'nursing care' remains the unifying concept that allows nurses to recognise one another.

Nurses can take back the leadership of their own profession by taking a stand against those who would subvert our true identity and purpose. Our individual actions will make all the difference as nurses in clinical and support roles assert their expertise and re-establish nursing care as the central role for nurses in all care contexts; and as nurse managers refocus on managing the environments in which nursing care occurs by ensuring that there are sufficient staff, provisions and time to enable safe and effective nursing interventions; and as nurse academics once again build students' understanding of nursing expertise in delivering nursing care and comfort, and helping those in need to adapt in healthy ways to the situations they are in or are facing.

Whatever we do, the next generation of nurses will be shaped by our awareness of events and processes that affect nursing and our ability to interpret and effectively respond to issues and opportunities that will benefit those in our care. It is simply unacceptable for nurses to abdicate responsibility for their profession by leaving it up to others to shape. It is our profession and we will develop it in ways that continue the nursing narrative of skilled, sensitive, safe and effective care to those who need us. Our nursing narrative must never again be endangered by pragmatism and neglect.

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Distinguished Life Fellow
Professor Patricia Dunning AM FRCNA(DLF)

Merit Award (Fellow/Member)
Recognition of merit for service to humanity
Mr Daniel O'Neill MRCNA

Merit Award (non-RCNA member)
Recognition ofmerit in advancing the profession
Mrs Fay Smallman

International Achievement Award
Professor Jan Dewing

Patricia Slater Award
Mr Mathew Moroney MRCNA

Gertrude Berger Award
Mrs Sharon Teale