Island Ingenuity

It is indeed a great honour to deliver the inaugural oration for the Australian College of Nursing this evening. As many of you are aware, from 1949 the former NSW College of Nursing, and the former Royal College of Nursing, Australia, served Australian nurses for over sixty years. They did this through developing and maintaining the highest principles of nursing practice and education, policy development, leadership and ethical standards. Following three years of discussion and consultation the synergy between the respective colleges was recognised through a positive member vote supporting unification. This vote occurred at two Extraordinary General Meetings held simultaneously on November 30, 2011. Tonight is another important opportunity to congratulate and celebrate all those involved in the three long years of discussion and the complex process of unification. Australian nurses now have a strong and diverse professional voice through the Australian College of Nursing.

I would also like to congratulate the Board on their choice of the theme for the 2013 Forum, *Success through Synergy*. This theme, which focusses on working together and the spirit of collaboration, is central to my presentation this evening, which I have entitled *Island Ingenuity*. This story weaves together reflections on my history of being a nurse, against the backdrop of living in Tasmania.

In her introduction to Tasmania, *The Tipping Point*? Julianne Schultz (2013:7,8) writes: ‘Tasmania occupies a unique place in the national imagination and it has been and continues to be the site of both extinctions and reinventions’. Schultz further reminds us that ‘the challenges Tasmania now faces are relevant to the whole nation’. While Shultz is referring to much more than health alone, these challenges are relevant because of the inextricable link between health and all other aspects of our lives. Indeed, because Tasmania may be viewed as a ‘living laboratory’, to some extent a ‘closed system’ or a ‘microcosm’, the challenges, and I would also suggest, opportunities that it now faces, are particularly relevant to all Australian health care professionals.

I have not always lived in Tasmania but when I was fifteen years old my family settled in Hobart. In no time at all I recall being fascinated with Tasmanian culture and in particular the way in which Tasmanians viewed themselves. In 1977 I came upon Dombrovskis’ and Miller’s book *The Quiet Land*. Let me read you a snippet of Nick Evers’ foreword. ‘West, along the 42nd parallel—as far west as the lonely southern reaches of Argentina the west winds have free play
across 200 degrees of longitude. The Westerlies have been no less influential than Bass Strait in shaping the face of this island. The nature and pattern of settlement in Tasmania both mirror its strength and constancy of those winds’. While Evers refers to ‘the slow momentum of progress on the island’, which he argues reflects the ‘economic handicap of remoteness’ he also highlights a unique set of values as the Tasmanian people’s response to their environment.

This mystical island of Tasmania, the ‘jewel of Bass Strait’ has, according to Jonathan West (2013:50), ‘a darker reality’. In his somewhat controversial and confronting essay, West tells us that ‘it seems not to matter on which measure is chosen, Tasmania will likely finish last’ and that, ‘what’s happening in Tasmania is not an exception but a microcosm for a major part of Australia’. Similarly, the State of Public Health (2013:3) report also suggests that ‘Tasmania’s overall health status more closely parallels that of regional Australia’. Of concern, however, the report highlights that the challenges for Tasmania are further compounded with an ageing demographic.

So what is happening in Tasmania? Doctor Roscoe Taylor, Director of Public Health in Tasmania, states in the same report that ‘serious health issues are emerging in our population many of them preventable’ (2013:2). It seems that while Tasmania's mortality rates are down the preventable mortality rates remain significantly higher than the national average (2013:3). Added to the ageing demographic in Tasmania there is an expected rise in the incidence of diabetes mellitus, cancer, ischemic heart disease, strokes and intentional self-harm (2013:6). A closer look at the health statistics for Tasmania also reveal that there are some regional differences, particularly those associated with the social determinants of health and the influence of these on health outcomes (Tasmanian Health Organisation North, Corporate Plan). In general there is poorer health in the Northern parts of the State where approximately half of the population resides. While the report is concerning for all Tasmanians, Taylor (2013:2) highlights that there is cause for optimism if the opportunities for health care improvement ‘are converted into sustained strategies’. I agree there is little doubt that we, as a nation, have significant challenges before us if we are to address the ‘darker reality’; by which I mean the preventable serious health issues evident in our Indigenous Australians and also in our non-Indigenous regional population.

Hobart shaped my earliest understandings of Tasmania, when I attended secondary school there in the early seventies. Upon matriculating at seventeen, I sought career advice from friends and family and everything pointed in one direction. Nursing would suit me – they all advised… it ticked all the boxes. I could live away from home, the hospital was just down
the road, I would get trained and paid and it was a worthy profession to join. I commenced an apprenticeship in nursing at the Royal Hobart Hospital in the early nineteen seventies and I was fortunate to have nurse educators, who at that time had rare and recent higher education qualifications in nursing education. I say ‘fortunate’ because their teaching was academically grounded in a strong philosophy of patient centered nursing care. It was during my first few weeks of nurse training that my academic passion around the experience of illness emerged. I was sent to an oncology ward after preliminary training school where I cared for a young woman, who I will refer to as Evelyn, through the last week of her life. I recall thinking that Evelyn deserved a nurse with far more experience than me and that at just seventeen, I required far more preparation than the mere six weeks ‘training’ I had received until then. Nonetheless, ‘it was the conversations that I had with [Evelyn] that fixed my interest on the experience of being ill. She told me her story of pain and suffering in such a way that it became firmly etched upon my memory’ (Fassett & Gallagher 1998:24).

After becoming a registered nurse, the next few years of my life was a mixture of having three children, leaving Tasmania for a while only to return again. At this time I worked as a nurse in aged care and at a private specialist medical practice. Then, in my late twenties, I did the unthinkable…well to Hobartians anyway! I moved to the far-flung region of the North West Coast. Friends and family indulged with more than a pinch of skepticism my explanations for leaving Hobart. I told them that I had found the richest chocolate brown soil imaginable, breathtaking scenery and that I wanted to live on a small farm. In part it was true but it was also a decision bound in the politics of ‘coming home’ that fuelled my desire to live somewhere other than Hobart, in what would now be my ‘home’ State. I wrapped myself up in a rural lifestyle and bought an Angora goat stud on the outskirts of Burnie, the coastal ‘capital’ of the North West. For a while there I had an idyllic existence, juggling raising goats and practicing ‘endoscopy nursing’ as well as the joys of being the mother of small children. It was also during this time that I came to understand just how parochial and divided by strange enmities our Tasmanian communities were, and still are today and how what I love about the uniqueness of each little community both moves it forward but also holds it back.

A few years later again, I moved to Launceston and worked in the Launceston General Hospital, graduating from the University of Tasmania with a Bachelor of Health Science and a Graduate Diploma in Aged Care. It was during these years that I also worked as a clinical teacher of undergraduate nursing students. Inspired by this experience to do further study, I enrolled in a Master of Nursing and I reflected once more on that young woman, Evelyn, whom I had met on the oncology ward all those years ago, but especially on her story of the illness
experience. By now I had formed the view that the socio-cultural dimension of the experience of illness was generally poorly understood and most often ignored in society at large (Fassett & Gallagher 1998). The intense subjectivity of illness and recovery from illness captured in the literary genre of illness narratives became my academic passion as a Masters student. For the next few years, my intellectual curiosity drove me to explore what we might call the ‘narrative structures of medicine and nursing’, the ‘narrative of illness in the social and human sciences’ and the ‘body and embodiment’ in nursing.

As a newly anointed academic I worked in the team that developed the first Bachelor of Nursing program in Tasmania, with our first enrolments in 1991. I simultaneously worked on the development of the course and taught in every year as the first cohort of students travelled through it. Most of the academics at that time were clinical teachers for two or three days a week and I was based full time at the local hospital. The key feature of this Bachelor of Nursing curriculum was that it was underpinned with uniquely close partnerships with health service providers, and in particular, the Tasmanian government’s Department of Health and Human Services. As well, working in the only University in Tasmania had some obvious advantages. That said, the disadvantages for all of us nursing academics at the time, which was often somewhat fraught with difficulties, were that we had no idea of just how successful our strong and innovative partnerships would be, and indeed, still are today.

By the time I had completed my PhD in 2004 I had been appointed Deputy Head of the School of Nursing and the Director of Learning and Teaching. The main challenge I had in this dual position was how to develop and provide postgraduate nursing courses at the University. These were required not only to economically sustain a School of Nursing but also to address significant work force issues in nearly all of the nursing postgraduate specialties. While a work force crisis in Tasmania may involve very small numbers, it was difficult, if not almost impossible for us to offer postgraduate nursing courses. None of our course proposals were considered viable by the University and our registered nurses studied everywhere except in Tasmania, many of them leaving the State to do so. In addition, I was acutely aware that the opportunities available to our undergraduate students and staff were often limited by our isolation. Economies of scale are difficult in Tasmania and while we do everything to encourage our graduates to stay we, necessarily, also support them to leave. It was also in the early 2000s that we had formed a strong partnership in New South Wales with St Vincent’s Private Hospital in Sydney through Professors Kim Walker and Jose Aguilera. Having worked in Tasmania, Kim recognised both our struggle but also our capacity to develop and sustain unique partnerships. The University commenced negotiations to offer our newly developed two-year fast-track
Bachelor of Nursing program with the former St Vincent’s and Mater Health Service at Darlinghurst. This was, and continues to be, a great success for students and staff alike.

In 2006 I was appointed Head of School and also in the same year, Chair of the Nursing Board of Tasmania. My first job as Head of School was to implement the establishment of a new campus at Darlinghurst I just mentioned. This was extremely difficult because as you might expect, in a highly competitive environment other nursing education providers in New South Wales did not necessarily welcome our arrival. Academic nursing leaders in New South Wales were rightly nervous and one leader summed up this nervousness for me by saying ‘imagine if we all played in your back yard’. At the time it was difficult for me to explain that they, and many more, were already playing in our back yard and, as a result, that many of our nurses were leaving to play in theirs!

Nevertheless, I knew that unless we formed strong partnerships outside of Tasmania our postgraduate and workforce challenges would continue to escalate. Later, through our international partnership with Denmark, I met Associate Professor Kerry Russell who at the time was the Director of Nursing with the former Sydney South West Area Health Service in New South Wales. Through this happenstance meeting and, together with our Danish colleagues, we explored the particular challenges we faced internationally in nursing and our potential synergies soon became evident. Establishing another partnership and our second boutique campus at Rozelle in New South Wales, we finally had the opportunity to offer postgraduate nursing courses in Tasmania.

When our new mainland campuses were noted in Tasmania I began to receive pressure to open a nursing campus in Hobart. Being the only capital city in Australia without a nursing campus was, of course, unacceptable but the parochial politics, which once again threatened to hold us back, required sensitive and careful negotiation. With the support of the Chief Nurse, Professor Fiona Stoker, the University successfully opened a nursing campus in Hobart and last year the Vice Chancellor, Professor Peter Rathjen, officially opened the new facilities on the Domain.

The partnership and synergy between the University of Tasmania and colleagues in New South Wales crossed the borders and boundaries that necessarily define us but at the same time often hold us back. The success of this synergy has meant much to the registered nurse workforce in Tasmania and to the School of Nursing and Midwifery. It is an example of what my colleagues in the Faculty would refer to as in the title of my oration ‘island ingenuity’. This ingenuity arises from our innovative ideas born in the challenges of the remoteness of our
isolation and successfully nurtured in our ‘closed system’.

Another example of this very same ingenuity was highlighted for me in 2007. Concerned with the rising incidence and lack of understanding of dementia particularly amongst the health work force, Professor Andrew Robinson, a registered nurse and Professor of Aged Care, and Professor James Vickers, Head of Medicine and a neuroscientist, got together. They developed a proposal to establish a translational neuro-science research center. Their compelling proposal, coupled with their motivation to make a difference, saw the Wicking Centre established in 2008 originally in partnership with Nursing, Medicine and the Menzies Research Institute. The Wicking Center, with funding from the JO and JR Wicking Trust (ANZ Trustees), brings together unique translational research collaboration between neuroscientists, social scientists, health service researchers, the health professions and disciplines in the Faculty, dementia design specialists, policy analysts, business consultants and educational leaders.

This particular blend of expertise brings innovation into all aspects of the care of people with dementia including treatment/cure potentials, service delivery models, workforce design, strategy and governance, educational delivery and public policy. Now, with four programs of research, the Wicking Centre is an important feature of the Faculty of Health Science and the State of Tasmania. This year the team launched the massive open online course, or the MOOC as it is known, in ‘Understanding Dementia’. This free open access program provides a vehicle to build awareness of dementia through a range of learning approaches. As my mother now has advanced Alzheimer’s disease a number of my family, including my 82-year-old father, were amongst the 9,000 people who enrolled. Reflecting on my own family experience I am compelled and passionate about the importance of raising awareness and improving the quality of care for those with dementia. While I am confident my mother receives the best available care it is by no stretch of the imagination an appropriate model of care for people with dementia. The successful multi-disciplinary Wicking team is an excellent example of how innovative we need to be to bring the appropriate expertise together to better position our health system in meeting the future demands of our ageing demographic.

Two years ago when one of my key mentors and the former Dean of Health Science, Professor Allan Carmichael, died, I reflected on how I might spend the last part of my career as a nurse. I was aware of the privilege that had been afforded me through my experiences of nursing practice. I was also mindful of how privileged I had been to work in the profession of nursing. It seemed to me that our innovative and collaborative profession is capable of the strong leadership that I believe our health system now requires to strategically and sustainably reinvent
our fundamental approaches to health care delivery. I truly believe that now, more than at any other time in our history, there is a growing willingness across the professions to look at our issues through multiple lenses and collective wisdom. I saw an opportunity to work with all of the disciplines in the Faculty of Health Science and I was appointed to the position of Dean last year. Shortly after I was appointed however, I hesitated for a moment as I walked past some images of the previous Deans. I hoped that I could build upon their previous leadership and that they would agree that in challenging times, the spirit of collaboration would serve us well. It seemed to me that I had travelled a full circle because from my new office in Hobart, I could see my old room in the nurses’ home where I had lived all those years ago.

Initially, I attended to the churn of everyday business focussing inward as I gradually surrounded myself with a strong and capable team. Simultaneously, I needed to realign the Faculty of Health Science with the wider University before we could turn our gaze outward once more. The aspiration of the University of Tasmania to be ranked among the top echelons of research-led universities in Australia required the organisation to implement a number of initiatives which included: academic re-profiling; a professional staff review; a new operating and budget model, to name a few. The University also aspires to be characterised by its unique island setting and its distinctive student experience. For a Faculty of Health Science, with its core business of research and learning and teaching, we were also caught up in the external complex health reform and regulatory environment. In my early meetings with the Faculty Executive we all agreed that our future success depended upon changing our structure, further developing our key partnerships, developing and sustaining high quality courses and developing and building research capacity through our distinctive research themes. At a Faculty planning day the team discussed the importance of entrepreneurialism and innovation to the Faculty and they put forward ‘island ingenuity’ as an important feature of our new brand. Along with our developing mission to improve the health outcomes of all Tasmanians this required no further explanation; it captured what we are about and lifted our gaze above our disciplinary boundaries.

The Faculty Executive explored the possibility of changing our long-established shape to assist us in being more responsive, flexible and agile in order to collaborate across the disciplinary boundaries within the Faculty, the University and with our industry partners. The Faculty has now spent most of this year exploring a new structure and has settled upon a two-school model. Nursing and Midwifery, Human Life Sciences and the University Department of Rural Health will come together as one new School, and Medicine with Psychology and Pharmacy will come together to form the other new School. This does not mean that the current
disciplinary groups will merge or disappear; it is merely a structure, a form ‘fit-for-function’ if you will that enables and better encourages us to collaborate. Residing within these two schools there will be a number of health disciplines spread across a large number of geographical locations. Many of the disciplines offer courses through the multi-campus organisation, including in every major region in Tasmania and also in New South Wales. For our Faculty this is history in the making as we face the challenges upon us to find innovative solutions to our health concerns.

This consultative exploration of form and function in the Faculty specifically, has allowed us to have endless conversations about health, in general. At the very heart of these discussions we have considered new contemporary courses in the preventative health and chronic disease management space. In particular we have explored how we can influence the pernicious trend of a rise in diseases associated with obesity and inactivity, through a focus on active living. In Launceston for example, we aim to harness the synergy and potential through nursing and midwifery and the human life sciences, including exercise science. We have established a research center for active living and are currently exploring ways of connecting this potential with the North and Northwest communities. I would strongly suggest however, that the new thinking required to respond to the health workforce future needs in chronic disease prevention and management, is seriously considered by the nursing profession at all levels.

In nursing we have a more holistic view and understanding of the health landscape; we know that outdated models of care continue to prevail; that there is much to do in assuring quality and safety of patient care outcomes. And we also know that working to our full scope of practice needs better and more careful examination. As a profession we have demonstrated the value of nurse practitioners and, as the largest component of the health workforce, we can also further highlight our expertise and value in chronic disease prevention and management. Some new and innovative thinking in nursing will require education providers to invest in re-examining and further developing our nursing curricula. We must ensure that students of nursing are prepared for the challenges in health that I have discussed this evening.

While Tasmanians ponder on the future of their island and health care professionals and bureaucrats become increasingly concerned about the decline of the health of our communities, successful sustained strategies will require all of us to work together. In Tasmania it is possible to bring all of the leaders in health into the same room, at the same time because we have the advantage of being small and contained. We must, therefore use this opportunity wisely. Not only Tasmanians but all Australians need to identify and foster synergies and
partnerships across our parochial socio-demographic and federated geographic boundaries if we are to address the inequities of health evident in both our Indigenous and regional populations of Australia. I have spoken of the unique qualities of the Tasmanian people, and how their remote isolation gives them a strong sense of connectedness to place and each other. As a microcosm we can be viewed as a mirror reflecting back to Australia our shared ‘darker reality’, but also our shared ingenuity, optimism and opportunity.

REFERENCES

Tasmanian Health Organisation North, Corporate Plan For Financial Year Ending 30 June 2014.

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