

## THE HENRY PARKES ORATION 2015

# From Nightingale Nurses to a Modern Profession: the Journey of Nursing in Australia

Presented by Dr Georgina Willetts

Sir Henry Parkes Memorial School of Arts, Tenterfield  
17 October 2015

---

### Introduction

In the 200th year since Sir Henry's birth, I am honoured, as a descendent of Sir Henry, to have been given the privilege of presenting the 2015 Sir Henry Parkes oration. I am a professional nurse and my story is intertwined with the evolution of nursing as a profession. However, the story of nursing in Australia is also intertwined with my ancestor Sir Henry Parkes and his vision for both education and healthcare.

Nursing has always been seen as women's work, and this has created a troubled path that the profession has had to negotiate to legitimise itself. Today I am going to talk about the journey of nursing in Australia from its early days at the Sydney infirmary to its rightful recognition as a profession amongst the other healthcare professions in this country.

In 1981, at the ripe old age of 17, I began my training in the old hospital apprenticeship system akin to the Nightingale training schools. From then I have worked continuously as a nurse and midwife and have travelled the journey to the professionalisation of nursing initially achieved in 1986 in Australia. I undertook midwifery and orthopaedic training in the old hospital certificate system and then went on to transition my qualifications to academic standing, undertaking a conversion degree, two graduate certificates, a graduate diploma, a Master of Education and then finally a Doctorate of Education.

Identifying always as a clinical nurse, I took a turn on my journey in 2010 and moved into academia. From here I have learnt there are many ways to influence the profession, particularly through the education of our new generation of nurses but also through research into the profession of nursing. My doctoral research studied social practice in 'constructing the nurse's professional identity'.

Some of you will know the story of the evolution of the nursing profession in Australia, especially those in the audience who are nurses. This oration provides a good opportunity to reflect on the caring profession, its challenges and its journey. I hope when you do come into contact with a nurse, that your experience is one of a professional carer who has taken the time to critically hone their craft, a professional that I would be proud of.

### Sir Henry's influence and Nightingale

Let us go back to the beginning. Sir Henry Parkes had a clear vision of social reform, public education and public healthcare, and he also held a strong commitment to women having public roles. In 1866 he wrote to Florence Nightingale about his requirement for Nightingale-trained

nurses in the colony (Godden, 2006). Sir Henry became a pivotal character in establishing modern day nursing in Australia. As the political character he was, the arrival of the first nurses to the colony was the result of his ultimate discontent in the management of the Sydney infirmary: the government was putting money into the infirmary but had no say in its management. Sir Henry made moves to change this, through eliciting the support of the infirmary doctors, who were also unhappy with the happenings in the infirmary. Sir Henry was then able to cultivate their support. What both groups felt was needed were appropriately trained nurses to allow the doctors to practise the new ways of medicine.

The doctors' petitions had actually begun back in 1857 but it was not until a particular patient in 1866 that the involvement of Sir Henry led to the opportunity to contact Florence. A young patient, David Gibson, was found to be "filthy and covered in vermin" (Godden, 2006). This was actually not uncommon for patients in the infirmary at this time; however, this poor patient died. This was the impetus, "with a letter of complaint from the doctors identifying his death was the result of the absence of efficient nursing" (Godden, 2006), that enabled Sir Henry to gain the authorisation to contact Florence Nightingale and discuss the need for nurses who had undertaken her training to come out to the colony and introduce a Florence Nightingale style of nursing.

Before I go on with Sir Henry's story of introducing nursing into Australia, I must first articulate why Florence is so important to nursing.

Since the Crimean War in the 1850s Florence had gained much recognition for her new ways of working as a nurse and regardless of whether you are a fan of hers or not, some of her ways have left an ongoing legacy. Her philosophy that you nurse the patient rather than the disease introduced the holistic philosophy of nursing that continues today. She believed that healing the patient required good nutrition, including ensuring that the mouth was clean and food was nutritional, and this remains centrally important today in patient care. Patients need sunlight and air to heal, and this was ensured by the design of her wards, which always included a balcony where patients if need be would be wheeled out in their beds. The Germ theory was a new discovery and she introduced rudimentary isolation techniques. Tenterfield Hospital shows the effects of Florence Nightingale's reforms, with the building of a four-bed isolation ward in response to the potential for the 1918 Spanish flu epidemic to be brought back by returning WWI soldiers. Luckily this was only ever a potential.

Florence also identified that nurses should be calm, quiet and concise – difficult to achieve sometimes in our high-pressured environments today. She recognised pain and anxiety as obstacles to recovery, which was quite significant and new for nursing care in the 1850s. She also identified that there needed to be rules around sleep, and still today we have the afternoon rest period when visitors are restricted.

One of the most significant things she introduced into nursing practice was the recognition of nursing observations and nursing notes that were distinct and separate from medical observations and notes, and this, for nursing, was the beginning of evidence-based practice in our work. She went on to lead health reform in epidemiology and healthcare outcome statistics.

Overall, her legacy resulted in establishing a respected occupation for women and also the need for formal nursing education.

So Sir Henry was right at the cutting edge of healthcare reform back in the 1800s.

The letter from Sir Henry and the supporting head, Dr Roberts, took two months to reach Florence. This delay turned out to be timely as Florence had just received bad news that one of her proposals had been rejected by the Indian Government and there would not be the opportunity to train female nurses in India, so this opportunity to open a Nightingale training school in the colony was particularly welcomed.

Florence, however, did not just accept the request from Sir Henry; she made a significant change, rejecting the request of Dr Roberts for the nurses to be under the direct supervision of the doctors. Instead Florence insisted that a matron manage the hospital independent of the medicine. This was seen as a blow to Roberts, who wanted a doctor-led hospital, but Sir Henry supported

Florence and it was a workforce not subordinate to the doctors. Hence the embryonic start to the profession of nursing in Australia.

And so it was that Florence sent Lucy Osburn to the colony.

### **History of nursing in Australia: the legacy of Lucy Osburn**

Opened in 1816, the Sydney infirmary was nicknamed the ‘rum hospital’ because Governor Macquarie paid the builders in spirits in exchange for building the hospital. The reputation of the hospital was that of a squalid environment not particularly conducive to health care. In 1868 Lucy Osburn arrived in the colony to take up the position of Lady Superintendent (Matron); with her were five probationary nurses, all trained in the Nightingale training system in London.

The story of Lucy Osburn is an interesting one and reflects in many ways the trials and tribulations of nursing in the early 1980s, when it was attempting to establish itself as a profession.

Throughout her time in Australia Lucy Osburn’s career was very much intertwined with Sir Henry and he was a strong advocate for her and the Nightingale style of nursing she was introducing. But this was controversial. At this time a middle-class woman always held the senior nursing position, regardless of her experience. Lucy was of middle-class breeding but she was also the most inexperienced in the group of nurses that were sent out. The other nurses were of the working class and therefore automatically became subordinate to Lucy, which caused some disharmony throughout her time at the infirmary. The colony was also not very accepting of a woman taking such a position in society – a single middle-class woman who had her own rightful vocation (I won’t call it a profession as yet). Sir Henry Parkes received much opposition from many in government and in medicine (Godden, 2006).

Here it is important to note that the sisters of charity religious nuns were already functioning as trained nurses in the colony. What is significant to note is that these nurses were unpaid and under the direct authority of the medical staff. They were also, of course, of Roman Catholic persuasion and the colony was biased towards the protestant position (Godden, 2006).

However, what Sir Henry ensured was that the nurses under Lucy Osburn were paid and Osburn was also assured of her position of authority within the infirmary. This was challenged throughout her time in Sydney, but always supported by Sir Henry: he championed her position and was supportive of women in their own right. This was progressive for his time and laid the foundation for the potential development of the profession. Do not think that this was a happy ending: no indeed – much argy-bargy went on while Lucy Osburn was in Australia, between herself and the other nurses and also between herself and the doctors and the hospital board.

But the foundations were laid and eventually two of her nurses went on to bigger and better things. Haldane Turriff became the first matron of The Alfred Hospital in Melbourne and Annie Miller became head nurse at Brisbane. It is said that Lucy Osburn did not give a good reference for Turriff but needless to say the legacy of Lucy Osburn and Florence Nightingale and of course the vision of Sir Henry Parkes paved the way for the profession of nursing as we know it today.

### **My training in the teaching hospital system**

Although this very interesting history preceded me, my ignorance meant it was not until much later that I would come to understand how my own relatives were intimately intertwined with my future career path. I entered the nursing profession in 1981. I’m not really sure why I became a nurse; it was not something I had ever really considered doing. In fact I had planned to be a primary school teacher, but couldn’t stand the thought of studying for another three years. Little did I know I was entering a path of life-long learning.

I trained at the esteemed Prince of Wales/Prince Henry teaching hospitals in Sydney NSW. In fact I commenced my training on Parkes ground, the orthopaedic unit. This was certainly not planned, but Cobden Parkes had been involved in the architectural design of this beautiful new hospital

and hence the main building was named after him. I have apparently actually met Cobden but realised this only recently: at my father's funeral my cousin Selena mentioned that Cobden used to visit my grandmother. I have vague recollections of an elderly man having afternoon tea with my Granny when I was only a little girl, but I never realised who this man was – the ignorance of a child. What a shame this moment was lost on me.

Prince of Wales was built in the more modern design of hospitals today with single rooms, two-bed rooms and four-bed rooms, and in the early days of my training, men and women were separated.

Prince Henry, however, had been built out at Little Bay soon after Sydney infirmary (which has since been pulled down and become residential property). It was built as an isolation hospital and when I trained still had a 'leper colony' that the student nurses were not allowed to work in. This hospital was in the old Florence Nightingale style. The wards were huge areas that housed all patients in one very large room, with a veranda for those who were very sick or in particular need of fresh air. There were two ends of each ward, one for females and one for male patients. There was a large pan room at each end where we boiled the pans to complete sterilisation (which I was always causing to overflow as a result of easily being distracted by the patients).

Patients were not as sick back in those days; death was simpler and without our current technology people did not live with their many chronic diseases for nearly as long. Patients stayed in hospital for much longer: the average stay after relatively simple surgery was often 14 days (today you are lucky to stay more than five days if there are no complications), and there was a sense of community among the patients. Those who were on the mend would help those who were sicker, and for us as young nurses this created a very congenial environment.

Each student nurse wore a hat with the letters 'NEC' embroidered on it and a stripe for the year we were in. The letters stood for Nursing Education Centre but we always told the patients it stood for Nurses Eat Chocolate (ensuring a constant stream of chocolates from patients and visitors). The Nursing Education Centre of Prince of Wales and Prince Henry was a progressive school, and although our experiences on the wards were very traditional our schooling was very forward and the move towards professionalising nursing was strongly debated among our nursing teachers. Today some of those teachers are still in the forefront of progressing the nursing profession.

I was lucky to have been schooled in the older ways but on the cusp of change and it created a passion in me for nursing. In 1986 responsibility for nursing training was moved in its entirety into the tertiary sector in NSW, and it was recognised that nurses needed to be trained in the theory of nursing, not just the practice of nursing.

A new era was born, but it had not been without a fight.

### **The development of nursing as a profession**

The validation of the nursing profession in Australia is best recalled in Christine Duffield's paper 'Nursing in Australia comes of age' (1986). It was seen as particularly significant that nurses, like their other health care counterparts, also needed to be trained in the higher education system. But this was a struggle that took 20 years to achieve. From the 1960s to the 1980s, the deliberate move across North America, Australia and New Zealand to make nursing stand independently as a professional occupation was not without opposition, particularly from the medical fraternity. In the mid 80s nursing successfully gained entry into the tertiary education sector, but transfer of nurse training was not completely achieved until 1996.

Nursing now meets all the accepted criteria required for a profession as outlined by Greenwood (1957) and this can no longer be disputed, as I argued in my doctoral thesis. It has its own systematic body of theory, professional authority, sanction of the community, and regulative code of ethics.

Nevertheless, nurses continue to have trouble describing their work in a way that is comparable with other health professions, and there remains a lack of research clarifying nurses' identity within a professional context (Grice Robinson, 2013).

There also exists a strong notion that a profession entails a requirement to serve and perform within the public's interest, whilst having the ability to self-regulate, thus allowing for protection of the profession's own interests (Sullivan & Benner, 2005). Self-regulation is important as it ensures the profession controls its entry point through the completion of specific educational qualifications exclusive to that profession. All professions require the existence of professional bodies or associations that control and monitor conduct and performance (Giddens, 2013). Since the 1970s there has been a progressive and purposeful move for nursing to develop these attributes, and this has been successfully achieved.

The development of a code of practice, a code of conduct, and a competency-based framework under which all Australian nurses must be registered and which they must adhere to, further validate nursing as a regulated health profession. The competency framework was originally accepted in 1992 (AHPRA, 2012) and is regularly updated. It regulates the registration of registered nurses, enrolled nurses, and midwives. This competency framework consists of four key domains:

- professional practice
- critical thinking and analysis, which in the first iteration we had to fight for, as nurses were initially not identified as needing to think critically
- provision and coordination of care
- collaborative and therapeutic practice.

The Australian Health Practitioner Regulatory Board (AHPRA), which only came into effect in July 2010, requires all nurses and midwives to be registered in order to practise nursing and/or midwifery in Australia. This national registration was the result of a national law requiring regulated registration for the 14 recognised health professions within Australia.

It's interesting that we achieved federation five years after Sir Henry died in 1901 but it took until 2010 for health professions in Australia to be federated and gain national registration. As Sir Henry said, "the crimson thread of kinship runs through us all", but I must say, it sometimes takes a while to actualise this.

Now that I have established our right and position as a profession, why has nursing struggled so much with legitimising itself and also describing its practice?

Have you ever asked a nurse what they do and they have to think about what it is they actually do or what they actually don't do. It is not an uncommon phenomenon for nurses to struggle to define what their practice actually is – not all, but some.

### **The struggle to legitimise nursing as a profession**

The International Council of Nurses (ICN) defines nursing as:

Encompassing autonomous, and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy, and in patient, and health systems management, and education are also key nursing roles. (ICN, 2010)

This is an all-encompassing dynamic role.

Nurses and midwives make up the largest group (63%) of healthcare professionals within Australia (AIHW, 2012, p. 501). Nurses account for more than half (57%) of staff numbers in acute public hospitals in Australia in 2009/10 (AIHW, 2012, p. 411). Nurses can be defined as:

By far, the main occupational group in the (Australian) health workforce. Whilst registered nurses are tertiary trained and recognised as the professionals that manage the overall patient care. (AIHW, 2008, p. 445)

There continue to be shortages within the nursing workforce, and this is not isolated to Australia, with reasons cited as cultural change, globalisation, organisational values, professional values, and advancement in technology (Horton, Tschudin, & Forget, 2007, p. 716). Nursing is not always considered a career of choice today: “it is likely that the prevalent view of nursing as being undervalued and underpaid will have an adverse effect on recruitment.” (Miers, Rickaby, & Pollard, 2007, p. 1207). The nursing profession struggles to identify why it may have become a less attractive career option for many younger people.

Historically, nurses have had a troubled relationship with the image of nursing, and its legitimisation as a profession. Public perception often reinforces the negative image, as demonstrated in the paper by Morris (2010), where the public often viewed nursing work as “nasty, dirty, and unpleasant tasks” (Morris, 2010). This paper by Morris concluded that the public perception of nursing was removed from the reality, and was potentially damaging to the profession.

As well as an image problem, nursing continues to struggle with legitimising itself as undertaking autonomous practice, an important attribute of a profession (Liaschenko & Peter, 2004). The complexity of the context within which nurses work – the difficulty of identifying the *complex hierarchies* where nurses are “subordinate to organisational structures” (Liaschenko & Peter, 2004, p. 489) – further compounds the problem.

Much of the real work of nursing is intangible. Our therapeutic relationships, our patient advocacy and our holistic approach to care are often unseen, although certainly understood by the patient and family – when these aspects of care are not there, this is acutely felt by the patient (Grice Robinson, 2013, p. 43). However, this relative invisibility, along with our continued affiliation with medical knowledge and practice, has compounded our struggle to legitimise our autonomy (Aranda, 2007; Duffield, 1986; Grice Robinson, 2013).

Each year when nurses commence their degrees, we ask them what they think they will be doing, and they undoubtedly identify that their main role will be to carry out the doctor’s orders. Certainly we do carry out doctor’s orders; however, for most of our day the nursing voice ensures that we carry out patient care and meet patient needs with complete autonomy, and the nursing voice ensures that patient care and needs are communicated back to the other healthcare professionals.

Now that I have convinced you with my academic argument that nurses have professional status, where to from here? What is the future of nursing? Let us think for a moment about the fundamentals of nursing practice, claiming these as practices based on evidence, complex in their undertakings, that must be valued to ensure the future advocacy for patient-centred care.

### **The future of nursing and potentially healthcare**

To look at the future of nursing practice I am going to discuss three different contemporary aspects that have the potential to either strengthen or erode professional nursing work.

The first is its close affiliation with the body. Nursing work is complex and there are a number of stereotypes and “contradictory social meanings” (Wolf, 2014) that frequently stigmatise nursing practice. The increase in technology and the continued focus on science as the one objective truth continue to create challenges for legitimising nursing work. What I mean by this is that nursing work is intrinsically connected to the subjective nature of the patient and particularly the patient’s body. Our work involves activities that require a close relationship with the patient’s body and as

a result this can be seen as dirty work or menial work. We see the patient as a bio psychosocial being (Wolf, 2014) and our professional identities are closely tied to a relationship with the patient's body. This continues to reinforce the dominance of the doctor–nurse relationship and the idea of nursing as a complementary vocation (Wolf, 2014).

As a result nursing has created an exclusive culture where nurses talk and debrief amongst themselves. Talking about their work to someone who is not a nurse often risks being seen by outsiders as disgusting or revolting, reinforcing the stereotypes of nurses as sexual and/or sinful.

The sense of humour that is ever-present amongst nurses helps to normalise this identity within the profession. I remember as a student nurse visiting my father at the University of NSW where he worked. At the age of 17 I encountered my first death and I contacted Dad during my lunch break to tell him and he sat with me and he listened. I visited him many times on these sort of occasions and he told me years later how he used to feel quite nauseated by my stories. He never showed this so I was lucky, but certainly he was probably the only non-nurse I ever discussed these things with. You learnt very early that 'normal' people found these things disgusting. But nurses spend many a meal break debriefing or joking about some of the 'dirty work' we do and we learn to tell stories with much humour, reinforcing our professional prototype but also reinforcing the stereotypes. We too are products of our societies and we know that often what we do is not socially acceptable.

I believe one of the challenges that the future of nursing faces is not to run from the so-called 'body work' (Wolf, 2014) we so importantly do, but to embrace this, claim it and demand the respect needed for such practice. If any of you have been patients – and I am sure many of you have – it is a well trained competent nurse who you want to assist you with your activities of daily living – a professional who can assess you and use well developed clinical reasoning skills to determine your health needs and ongoing treatment while undertaking this 'body work' (Wolf, 2014). The move to increase the numbers of lesser trained nurses and unregulated workers particularly here in NSW "reinforces the tension that 'body work' can be undertaken as a more menial task by a lesser trained person, particularly lesser trained in critical thinking, clinical reasoning and nursing management".

So I put it to you, do you want a professionally trained carer looking after you? If so, then care needs to be valued; it needs to be owned and we need to continue to hold the positions to advocate for *our* patients. I know this may come at a financial cost and I do not have the answer to that, but I do know that once you start watering down the nursing profession you start watering down the voice of the patient.

The second aspect I will discuss is the price professional caring can have on the nurse. There is an increasing body of research, particularly nursing research, which is studying the phenomenon of compassion fatigue. I recently read a thesis on this and its effects on nurses. What is known is that healthcare workers working in high technology areas with patients with increasingly complex diseases frequently suffer negative personal outcomes.

Certainly in my doctoral research one of the surprising results was that the development of professional identity needed time and space often away from the patient bedside. This is what I would call sacred professional time. There is a tendency for health economists to see any time away from the patient as wasted time and therefore wasted money. This creates a danger that sacred professional space is being systematically eroded.

However, it is important that somehow these opportunities for developing professional identity are understood and preserved and valued, ensuring that newer generations are afforded the time to develop their professional identities constructively. There has been much organisational change that encourages maximum patient time – the lean thinking movement demonstrated that nurse to patient time is compromised – and although many of these studies potentially improve nurse–patient contact, there has been a loss of some of the traditional time that nurses spent preparing with other nurses to prepare for the management of the complexities of their shift. Increasing technology and increasing patient acuity due to sicker patients staying in hospital for lesser time result in a constant level of activity and stress throughout a shift. This of course is true of all the

health professions, but the significance for nursing is the need for the nurse to be consistently available to the patient.

Some of the contributing factors to compassion fatigue include the environment (as in the culture of the unit), the actual physical spaces where nurses work, constant pressures to meet KPIs, lack of recognition of professional autonomy and legitimatisation of the nursing role, and lastly personal factors, which of course can simply be the tiredness we all feel particularly if working shifts (Drury, Craigie, Francis, Aoun, & Hegney, 2014). In many ways this is a challenge for the current generation, with our increasing expectations to react and multitask and produce quick outcomes. For healthcare workers the added exposure to horrific, tragic, repulsive, violent experiences all transpiring within one shift results eventually in compassion fatigue and affects the health of our workforces.

So the challenge is to support and nurture the nursing profession, which requires investment in strategies to support ‘compassion satisfaction’. There is evidence that compassion satisfaction is linked to improvements in patient outcomes. We need resilient well-educated nurses, but these nurses need to work in environments that support their professional development, and are positive environments that value nursing (Drury et al., 2014).

Therefore my second proposition to consider for the future health of our nurses is to find some space either in the professional space or the interprofessional space to just ‘be’. Our undergraduate curriculums now include training in mindfulness, and personal as well as professional wellbeing. It is well recognised and growingly well documented that we need to actually care for the carers to ensure they can care for others.

The third and final aspect I will touch on is what Florence Nightingale started: evidenced-based practice in nursing and the now more contemporary phenomenon of translation of evidence into practice. So what is evidence-based practice in nursing? We know that Sackett and others in 1996 defined evidence-based medicine as: “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996).

This definition is also true of the nursing profession. But nurses need to be trained both to understand evidence-based practice and to develop the skills through critical thinking and analysis to undertake and utilise evidence in practice. We know that for this translation of research into quality care, evidence needs to be increasingly developed through professional leadership, professional autonomy, generation of nursing research and the continuation of higher education. Learning environments where critical thinking and increased utilisation of research in practice are imperative to maintain our standards of patient care (Florin, Ehrenberg, Wallin, & Gustavsson, 2012).

So my last proposition is to support and recognise that nursing is a contemporary profession based on evidence-based practice – the utilisation of evidence for the translation of better healthcare outcomes for patients.

## **Conclusion**

As the 2015 Sir Henry Parkes oration draws to a close it is of value to reflect on the pivotal position my great great grandfather had in the establishment of nursing in Australia. I have given you a very brief overview of Lucy Osburn our founding nurse and her successful establishment of Nightingale nursing due to Sir Henry’s continued support. I have also given you a very brief overview of my beginnings in nursing at a relatively turbulent time for nurses. I then clarified nursing as a legitimate profession and put to you some of the ongoing challenges of nursing and particularly nursing work and its intimate relationship to body work. I briefly discussed compassion fatigue and the significance of developing compassion satisfaction in our future nursing workforce and finally I drew on the need to continue the development of evidence-based practice in nursing through research and higher education.

As Sir Henry once said “no work worthy of achievement was ever attained without surmountable difficulties” (Warhaft 2014, page 10).

To ensure we retain a health care system with one of the highest standards of care, nursing professionals need to be valued and their future practices and education need to be supported.

## References

- AHPRA, A. H. P. R. B. (2012). National Regulatory Boards.
- AIHW, A. I. o. H. a. W. (2008). Australia's health 2008: the eleventh biennial report of the Australian Institute of Health and Welfare.
- AIHW, A. I. o. H. a. W. (2012). Australia's health 2012: the thirteenth biennial health report of the Australian Institute of Health and Welfare (pp. xv, 625 p.).
- Aranda, K., & Law, K. . (2007). Tales of sociology and the nursing curriculum: Revisiting the debates. . *Nurse Education Today*, 27(6), 561-567.
- Drury, V., Craigie, M., Francis, K., Aoun, S., & Hegney, D. G. (2014). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Phase 2 results. *Journal of Nursing Management*, 22(4), 519-531. doi: 10.1111/jonm.12168
- Duffield, C. M. (1986). Nursing in Australia comes of age!. *International Journal of Nursing Studies*, 23(4), 281-284.
- Florin, J., Ehrenberg, A., Wallin, L., & Gustavsson, P. (2012). Educational support for research utilization and capability beliefs regarding evidence-based practice skills: a national survey of senior nursing students. *Journal of Advanced Nursing*, 68(4), 888-897. doi: 10.1111/j.1365-2648.2011.05792.x
- Giddens, A. (2013). *Sociology* (7th ed. ed.). Cambridge: Cambridge : Polity.
- Godden, J. (2006). *Lucy Osburn, a lady displaced : Florence Nightingale's envoy to Australia*: Sydney University Press.
- Greenwood, E. (1957). Attributes of a Profession. *Social Work*, 2(3), 45-55.
- Grice Robinson, S. (2013). The unique work of nursing. *Nursing*, 43(3), 42-43.
- Horton, K., Tschudin, V., & Forget, A. (2007). The value of nursing: a literature review. [Review]. *Nursing Ethics*, 14(6), 716-740. doi: 10.1177/0969733007082112
- ICN, I. C. o. N. (2010). International Council of Nurses Conseil international des infirmieres = Consejo internacional de enfermeras (pp. 1 CD-ROM). .
- Liaschenko, J., & Peter, E. (2004). Nursing ethics and conceptualizations of nursing: profession, practice and work. *Journal of Advanced Nursing*, 46(5), 488-495.
- Miers, M. E., Rickaby, C. E., & Pollard, K. C. (2007). Career choices in health care: is nursing a special case? A content analysis of survey data. I. *International Journal of Nursing Studies*, 44(7), 209.
- Morris, V. (2010). Nursing and nurses: the image and the reality. *Nursing Management*, 17(1), 9.
- Sackett, D., Rosenberg, W., Muir Gray, J., Haynes, R., & Richardson, W. (1996). Evidence-based medicine: what it is and what it isn't. *British Medical Journal*, 312, 71-71.
- Sullivan, W. M., & Benner, P. (2005). Challenges to Professionalism: work integrity and the call to renew and strengthen the social contract of the Professions. *American Journal of Critical Care*, 14(1), 78.
- Wolf, A. K. (2014). Critical Perspectives on Nursing as Bodywork. *Advances in Nursing Science*, 37(2), 147-160. doi: 10.1097/ans.0000000000000028